STATE TITLE V BLOCK GRANT NARRATIVE
STATE: MA
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

Massachusetts hereby attests to all of the Assurances and Certifications required for this Application. Copies signed for this application are on file with the Massachusetts Department of Public Health and are available upon request to either the Title V Director or the Department's Chief Financial Officer.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

A public hearing will be held in the fall, in a centrally located site, to allow formal annual public comment on the MCH Block Grant. The MPDH and EOHHS no longer do joint hearings for Alcohol, Drug Abuse and Mental Health Services Block Grant; Preventive Health and Health Services Block Grant; and the Women, Infants and Children (WIC) State Plan. The hearing is publicized and both oral and written comments are encouraged.

We also plan to make the Application/Annual Report available to the public through our website (as well as through TVIS). Additional comments will be solicited through that mechanism. We also encourage input and comment throughout the year. Our extensive participation in numerous advisory committees, community coalitions, and similar groups assure on-going input from the public and ready access to the state Title V program by many people and organizations.

Our emphasis this year has been on getting extensive and broad-based input into the Five-Year Needs Assessment and the development of Priority Needs and new State Performance Measures. These activities included a number of public input opportunities and initiatives, which are presented in more detail in the Needs Assessment document. Of particular note is the direct involvement of over 50 parents and 36 youth in focus groups, and statewide and regional meetings with many provider groups and interest organizations and task forces (e.g rural health, adolescent health, health insurance).

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

The people of Massachusetts enjoy better overall health status and access to health care services than in many other states. These benefits derive in significant part from favorable natural resources, relatively high levels of income and education, a diverse economy, and a history of strong legislative support for funding health and social service programs. Massachusetts' strong public health leadership, both in state government and in community and advocacy organizations, is also a factor. The Bureau of Family and Community Health (BFCH), within the Center for Community Health, is the Title V program. As such, it plays a key role in assuring access to comprehensive multidisciplinary service networks and systems. It emphasizes public/private partnership and network collaboration. A major focus is on the at-risk and under-served populations of the Commonwealth whose health status and access to care may be compromised. The Title V program is well-positioned and has long standing relationships with others outside as well as inside state government who address inadequate or poorly distributed health care resources. The MDPH and Title V have been active participants in a number of collaborations to address disparities.

All of the topics discussed in this Overview are presented in greater detail in our Five-Year Needs Assessment.

Geography and Demographics
Massachusetts is the sixth smallest state in landmass, measuring just 150 miles in its longest direction; however, it ranks 13th in population. Of Massachusetts' estimated 6,349,097 residents, according to the Census 2000, 26% (1,675,113) were children and youth through 19 years of age and 22% (1,422,476) were women ages 15-44. For 2004, the Census Bureau estimates the Massachusetts population at 6,416,505. Massachusetts is a relatively dense and urbanized state. The Census 2000 recorded nine percent of Massachusetts' residents living on the eastern seaboard in Boston (pop. 589,141), the state capital and largest city. Nearly 44% (43.7%) were living within the combined area of metropolitan Boston, Cambridge, and Quincy. After Boston, the next two largest cities are Worcester in central Massachusetts (pop. 172,648) and Springfield in the west (pop. 152,082).
There are also numerous smaller cities in Massachusetts, many of which are historically based in the mill industries, as well as island populations. In eastern Massachusetts, there are 1,500 miles of coastline on the Atlantic Ocean. Two islands, Nantucket and Martha's Vineyard, are located 16 and 5 miles off the Cape Cod shore. With a combined year-round population of approximately 24,500 and a summer population that swells to three times that number, these rural island communities face particular challenges in meeting their health care needs.

Rural areas predominate in the western section of the state, where the Berkshire Mountains separate many small towns with limited health services. Franklin County in the northwest has just 102 people per square mile. About 18.5% of Massachusetts' residents live in 193 communities in the west and other parts of the state that meet one of the several federal definitions of rural. These communities cover about 65% of the state's landmass. Farming is still a significant industry in rural areas. To facilitate understanding of rural communities, MDPH and the Massachusetts Rural Health Advisory Council have clustered geographically and historically related rural communities for analytic purposes, calling them rural clusters.

The entire state is incorporated (there are no frontier areas) into 351 cities and towns, which are the functioning units for most local services, including public health, below the state level. There are no county health systems. However, the Commonwealth's cities and towns have been grouped into 27 Community Health Network Areas (CHNAs). In each CHNA, health and human service providers come together with residents to engage in systematic community planning, building on existing coalitions and cooperative efforts. For emergency preparedness, the state has been clustered into 10 different geographic areas. The Executive Office of Health and Human Services (EOHHS) utilizes six regional clusters, which the Department of Public Health recognizes. Other EOHHS Departments use variants of these regional clusters.

The state's overall population grew slowly in the 1990s (up 5.5% from 1990 to 2000, that modest increase due only to immigration). The most recent population assessment indicates that Massachusetts has experienced a decrease in population.

Socio-demographic Factors
Immigration and Race/Ethnicity Trends
Racial and ethnic minorities made up more than 12% of the state's population in 1990 (black non-Hispanics at 5%, Hispanics at 4.8%, and Asians at 2.4%). A decade later in 2000, minorities accounted for more than 16%, with Hispanics at 6.8% surpassing blacks (5.4%), Asians (3.8%), and two or more races (2.3%). By 2010, Massachusetts' population is projected to be 6,690,740, with minority populations continuing to account for population growth. Hispanics are projected to increase by more than 38% and blacks by 32%. In several Massachusetts communities, including Boston, minority groups constitute the majority of the population.
In 2000, Massachusetts ranked 8th in the U.S. in its population of immigrants -- many of whom arrived within the last decade. A 2005 report concerning Puerto Ricans and immigrants found that one in seven residents of Massachusetts was born in the U.S. territory of Puerto Rico or a foreign country. In 2004, these residents made up 17% of the labor force. Immigrants play a vital role in Massachusetts' development and will continue to play the main role in our labor force growth for the foreseeable future. Estimates of immigrants and refugees may vary due to the inherent difficulty in counting changing populations whose language is not English and who experience cultural isolation. The following countries provided the largest percentages of Massachusetts' newest citizens: Portugal, China/HK/Taiwan, Dominican Republic, former USSR, Haiti, Vietnam, Italy, India, El Salvador and Brazil. Since the Census 2000, the hospitality industry has recruited a large of number Brazilians; almost one in five immigrants entering the state from 2000 to 2003, was Brazilian.

Immigration from Europe (overall, with exceptions noted above) and Canada has decreased over recent decades. Puerto Rican "in-migration" to Massachusetts has also decreased. Nearly half of all recent immigrants are from Latin America and the Caribbean; almost one-quarter from various countries in Asia. In addition, smaller numbers of populations increasingly come from varying linguistic groups in countries of Africa. Decreases in births among women born in the US simultaneously with increasing births among foreign-born women also contribute to changing demographics in the state.

Nationally, the influx of Spanish speakers has outpaced the immigration of other groups. Massachusetts differs in that its foreign-born population is diverse across multiple race and linguistic groups and within racial categories. Understanding this phenomenon helps us examine health disparities among broad race groups--white non-Hispanic, black non-Hispanic, Hispanic, Asian, and American Indian--and is crucial for understanding differences in disease risk, health outcomes, and inequities in the delivery of medical care. It is also important to look within each broad racial group. In some instances, there are greater differences in outcomes and risk among ethnic groups within a race category than between race categories. The following sections provide a brief overview of the various population groups; additional details are provided in the Needs Assessment.

Note that Census 2000 allowed individuals to identify more than one race category when responding. In order to account for this change, MDPH created the MDPH Population Estimate for 2000 that accounted for individuals who checked "some other race alone," "some other race in combination with other races," and those who indicated more than one race. The figures below are based on this method and they may differ somewhat from others in this document.

Asian: Since the 1990 census, the Asian population has grown by 74%. It now comprises approximately 4% of the total population and 26% of the foreign-born population. Most Asians (72%) are foreign-born. Although the largest ethnic Asian group is Chinese (35% of the Asian population), 11 other groups have been identified (in decreasing order of Asian population share): Asian Indian, Vietnamese, Cambodian, Korean, Japanese, Filipino, "other Asian," Laotian, Thai, Pacific Islanders, and Pakistani. Each ethnicity has different customs, health beliefs and language, and differs markedly

in socioeconomic indicators. Boston, Lowell, Cambridge, Quincy, Worcester and Brookline are cities with the largest Asian populations.

Black: Blacks are 6.2% of the MA population. About 24% were foreign-born (66% from the Caribbean and 26% from Africa). The birth certificate enables mothers to identify both their race and ethnicity. These include: African American, Haitian, Jamaican, Cape Verdean, Nigerian, Barbadian, Other African, Other West Indian/Caribbean. In addition, the foreign-born population has significant representation from: Western, Eastern and South Africa, Trinidad and Tobago. These ethnic groups have different languages and customs. Although some countries might have English as one of the official languages, most residents maintain tribal traditions and languages, thus making it difficult to categorize them with common attributes. An increasing number of individuals are entering as refugees or fleeing the conflicts in Africa. Blacks can be found in communities throughout the state with larger concentrations in: Boston, Springfield, Brockton, Worcester, Cambridge, Randolph, Lynn, Lawrence, and Milton.

Hispanic: The Hispanic population grew by 49% between 1990 and 2000. Nearly half of all the Hispanic people who arrived in MA between 2000 and 2004 were from Latin America and the Caribbean. Hispanics were the largest minority group identified in Census 2000 and the fastest growing population group in MA. Thirty-one percent are foreign-born and 23% were born in Puerto Rico. In most other US states, Mexicans are the largest group within the Hispanic population.

As with other broadly defined groups, Hispanics are often assumed to be homogenous in language and customs. This is not the case with Hispanics in Massachusetts. Puerto Ricans comprise the largest group (approximately 47% of all Hispanics in Massachusetts), although their numbers are falling. But in Massachusetts there are numerous other ethnic populations, including: Other Hispanics, Dominicans, Mexicans, Other Central American, Salvadorans, Other South American, Colombians, and Cubans. Boston had the biggest Hispanic population, but Lawrence had the largest concentration (60% of its residents). In addition, 12 other communities have Hispanic populations totaling more than 10% of the population: Chelsea (48%), Holyoke (41%), Springfield, Southbridge, Lynn, Worcester, Fitchburg, Lowell, Salem, Leominster, Framingham, and New Bedford.

Unauthorized Immigrants: A 2005 study estimates the number of "unauthorized migrants" (encompassing individuals often termed "undocumented") in Massachusetts to be between 200,000 to 250,000. The unauthorized population has been increasing since the last half of the 1990s and in Massachusetts is estimated to be between 20% and 29% of the foreign-born population.

Children: Of children age 17 and under, 75% are white non-Hispanic (compared to 84% for the total US population), 7% are black non-Hispanic, 11% are Hispanic, 4% Asian, and 1% other. These figures are for families who chose to select one race category only. An additional 3% of families selected more than one race category to describe their children.

Language and Linguistic minorities
The recent shift in immigration, away from European and other English-speaking countries, to those where English is not the primary language, presents challenges for Massachusetts. An increasing number of new immigrants do not speak English at all, or do not speak English well. The 2000 Census recorded almost 1 in 5 MA residents (18.7% in MA compared to 17% in US) 5 years and older who spoke a language other than English at home. Of those, 22% spoke English "not well" or "not at all." This is a significant increase from the 1990 census when only 1 in 10 (12.4%) residents fell in that category.

It is estimated that more than 150 languages are spoken in Massachusetts. Spanish-speakers accounted for 30% of those who speak a language other than English; 51% speak some other Indo-European language; 15% an Asian or Pacific Islander language; and 4% spoke some other language. Among those who spoke Spanish at home, 27% described their ability to speak English as "not well" or "not at all." A labor market study indicates that in 2000 almost 137,000 adult immigrants and Puerto Ricans did not speak English at all, or did not speak it well.

The Massachusetts Department of Education First Language Not English (FLNE) Report provides data specific to children. It identifies those communities whose FLNE public school population was 10% or more and provides information on the smaller subset of children who are unable to perform their classroom work in English (Limited English Proficient students). These data are useful indicators of younger families who may be linguistically isolated or experience increased need due to their limited English proficiency. In 2002, 1 in 7 public school students had a language other than English as the first language. In 1 out of 2 FLNE students, Spanish was the first language. Of these more than 37% were identified with Limited English Proficiency. In 42 communities FLNE students make up 10% or more of their student body and in another 23 communities FLNE students comprise between 5 and 9% of the student population. Children in Massachusetts classrooms speak 132 languages. The more frequently encountered languages are: Spanish (49% of total FLNE), Portuguese (10.3%), Cape Verdean Creole (6.1%), Chinese (5.9%), Vietnamese (4.3%), Haitian Creole (3.2%), Khmer (3.19%), Russian (2.8%) and Arabic (1.2%).

Poverty and Disparities
Massachusetts is a comparatively wealthy state with a diversified economic base that includes health care, education, finance, insurance, telecommunications, computer technology, biotechnology, tourism, farming, and fishing. In 2003, the median family income was estimated at $67,527 compared with $52,273 for the nation; only 3 states (New Jersey, Connecticut, and Maryland) had higher median family incomes. The state had the second highest percentage of college-educated individuals (36%). The percent of children under 18 living in poverty in 2003 was estimated at 12.3 compared to the national average of 17.7; 9 states had lower poverty rates. Based on 10 key indicators measuring child well-being in 2001, the Annie E. Casey Foundation Kids Count 2004 rated Massachusetts equal or better than the national average for each of the 10 indicators, ranking ninth compared to all other states. A child born in 2003 in Massachusetts has a life expectancy of 78.5 years compared with 77.6 for the US.

Yet disparities between wealthy and poor, educated and not, persist. Massachusetts showed an improvement from 1996 to 2001 in only 4 of the Kids Count indicators. While lower than the national averages, poverty rates for families and for individuals have increased since the 1990 census. Significant disparities exist with poverty rates for children in poorer urban and rural areas.

Although incomes are high, expenses are as well. Massachusetts has the fourth highest renter-occupied housing costs and the fifth highest owner-occupied housing costs .in the nation. A 2004 report by the Massachusetts Family Economic Self-Sufficiency Project documented financial stress for low-income working families, estimating that 25% of Massachusetts families and nearly 50% of urban families, earn less than the income needed to meet their basic needs without pubic or private supports. The report found that between 1998 and 2003 the real cost of living had increased from 17% to 35% depending on the region of the state. It estimated that to make ends meet, a family with one adult, one preschool child, and one school-age child needed to earn 228% to 336% of the federal poverty level.

Paralleling national trends, Massachusetts has experienced an increase in the number of homeless families and individuals since the 1980's, increasing pressure on shelter use. Families constitute about 58% of the homeless population in Massachusetts and about 20,000 children in the Commonwealth are homeless (51% of them under the age of 5).

The three-person income limit for the Department of Transitional Assistance (DTA) Emergency Assistance Program in FY 2003 was $15,284. During this period, one-half of the sheltered population had an average annualized income of $4,584, all of which was cash assistance. Over 90% of all homeless families in shelters receive food stamps. The food stamps caseload in Massachusetts increased from 153,724 in March of 2004 to an estimated 165,969 in February 2005.

After financial problems and unemployment, substance abuse was the most common reason reported for homelessness among users of the shelter system in the state. Domestic violence is one of the

main reasons that women seek shelter, and is a situation affecting many homeless families in the Commonwealth.

Health Insurance, Health Services, and Health Care Reform
Massachusetts has been a leader in health care reform and is developing strategies to expand coverage to the estimated 460,000 uninsured in the state. The current system provides access to health care across the state, with the highest quality ratings in the nation. The state has a strong network of high quality, not-for-profit hospital and community-based safety net services for the poor and disabled, as well as a generous culture of employer and public subsidized coverage. Thus the state has a low uninsured rate of 7%. The state has made a large commitment to supporting care for the uninsured primarily through the state's Uncompensated Care pool.
Nevertheless, several issues exist that challenge the current and future systems if they are not addressed. Health care costs are growing at unsustainable rates. State health care cost increases, primarily Medicaid, are crowding out other basic services. The cost of care for the uninsured is estimated to be more than $1 billion annually and must be recognized as everyone's problem. The regulatory environment has limited insurer innovation and there is a lack of transparency of both price and quality.

As in other states, Massachusetts' health delivery system has been impacted by many competing and related factors over the last decade. In its 2003 release, Massachusetts Health Care Trends: 1990-2001, the Massachusetts Division of Health Care Finance and Policy addressed six major paradigm shifts that have had and continue to have implications for services to infants, children, youth, and pregnant women:
State-initiated Increases in Access to Health Services: Interlocking state laws and programs have decreased the number of uninsured through Medicaid expansion, small group and individual insurance reform, and the Children's Health Insurance Program (CHIP). This accounts for Massachusetts' rank of 4th in the nation for health insurance coverage, with just under 7% of the population uninsured in 2005.
Dilution of HMO Networks: Massachusetts HMOs started the decade with tightly controlled exclusive provider networks and lower premium costs to purchasers. It ended it with nearly identical universal panels of providers under pressure from consumers for greater choice, but left HMOs with deep discounts for volume and shrinking fiscal margins.
Health Care Role Blurring: Clear distinctions among providers, insurers, payers, purchasers and patients have become blurred as doctors began to share financial risks with insurers, insurers became providers who employed doctors and owned hospitals, employers became self-insured, and Medicaid moved from payer to purchaser as it expanded managed care, etc.
Changing Health Services Cosmology: Health care became less centralized around hospitals as managed care, enabled by technology and pharmaceuticals, reduced hospitalizations and inpatient days dramatically over the decade. This created a bulge in home health care and prescription drug use as well as a more fragmented health care landscape, presenting challenges to both professionals and patients.
Swings in Regulation: The decade saw a shift away from strict rate-setting to calls for a return to state involvement by patient advocates and industry experts. The cause of this is the dismal fiscal condition of many Massachusetts hospitals, nursing homes, and community health centers as well as lack of oversight over provider closings, sales of institutions to for-profits, medical errors, etc.
Increased Consumerism: The long-standing paternalistic patient-physician relationship has been challenged, as patients become clients and consumers and more information and options become available.

In response to these issues, the Governor is proposing a health care reform initiative that is a "comprehensive, market-based program that will focus on controlling health care costs and increasing access." The plan has four main elements:
-- Increased Medicaid enrollments (106,000 persons);
-- Affordable health insurance premiums for individuals and small businesses through a new Commonwealth Care program for those with incomes up to 300% FPL (204,000 persons -- those who can afford insurance but don't buy it, the short-term unemployed and new employees);

-- Safety Net Care managed care plan for those with incomes between 100-300% FPL to replace the Uncompensated Care Pool (150,000 persons); and
-- Transitional coverage to new employees and the short-term unemployed (36,000 persons)

In addition, two proposals have been put forth in the Massachusetts Legislature. It is expected that the active discussion related to expanding access to health care coverage will continue over the next year, as there are many building blocks in place and momentum is growing. Expansion of coverage will greatly benefit both children and families.

The Uninsured and Insurance Coverage in Massachusetts
Current estimates are that 93% of the Massachusetts population is insured either through employer, individual, Medicare, Medicaid or another public source and that there are approximately 460,000 uninsured persons. Approximately 12% of the uninsured are children, remaining at 3.2% of the total population statewide; an improvement from 4.5% in 1998. Seventy-one percent of children below 200% FPL are insured by MassHealth and 86% of children above 200% FPL are covered by their parents' employee insurance.

The highest rates of uninsurance are found among Hispanics, followed by blacks and Asians, which correlates with unemployment status. Adults age 25 and older are the majority of the uninsured. But 25% of the transitioning young adult population aged 19 to 24 is uninsured. The northeastern part of Massachusetts has the highest proportion of uninsured residents (12%).

Massachusetts has one of the highest penetrations of managed care in the nation. The market continues to be dominated by locally based, not-for-profit organizations (there is one locally based for-profit health plan in the state), and these health plans consistently rank highly in national consumer satisfaction ratings and on HEDIS measurements. The health plans, especially HMO-like plans, in Massachusetts (as well as throughout the country) have come under increasing pressure to expand services and reduce restrictions. Consumers and employers have demanded a broader choice of doctors and hospitals, resulting in a move away from tightly managed health benefit products, increased PPO and POS product offerings, and reduction in the number of procedures requiring prior authorizations. Consolidation among hospitals and physician groups has increased their bargaining clout. The Legislature also enacted laws mandating coverage of specific types of services and new measures for regulating health plans. These changes combined with the aging of the population, the accelerating introduction and use of new drugs and medical technologies, have led to higher health care costs.
In response to the rising cost of health care and employers' desire for more choice in how they control their health care costs, health plans have continued to modify the insurance products available. This has included significant increases in deductibles and co-pays as well as tiered deductibles based on the site of care. Consumer-driven plans are currently being offered by more and more employers. Pediatricians have expressed concern that the consumer-driven plans may result in families delaying care, electing not to have follow-up care or making choices based only on price.

Medicaid and SCHIP
MassHealth, as the state Medicaid program is known, provides comprehensive services through Medicaid, SCHIP, Children's Medical Security Plan and CommonHealth. Currently 985,000 individuals are enrolled in MassHealth. Of this number, 416,500 are children up to the age of 18. With identification of approximately 106,000 additional individuals as Medicaid eligible but unenrolled, steps are underway to increase outreach and facilitate enrollment of all who are eligible. The newly renewed Medicaid 1115 Waiver expands coverage to some selected special populations within the existing Medicaid populations and allows the state to establish a new program referred to as Safety Net Care. This program would provide coverage to eligible uninsured individuals within certain FPLs. Currently, multiple options such as Safety Net Care are being considered to redesign the health care delivery system for MassHealth managed care members and other publicly assisted populations.

MassHealth began moving toward managed care in 1991 with its first HCFA 1915b waiver and continued to expand this system with its 1115 waiver and SCHIP. Most children and pregnant women

covered by MassHealth, including SSI recipients, were enrolled in a managed care program by 1998 with these exceptions: CommonHealth, for which managed care enrollment is optional; the MassHealth Family Premium Assistance Program (MHFPAP; and children and youth in state custody. A total of 603,373 or 62% of all 985,000 Massachusetts MassHealth enrollees are currently in managed care plans.

The Medicaid managed care program is very well integrated into the overall health care delivery system through two different managed care program types: Primary Care Clinician (PCC) and Managed Care Organization (MCO). The years 2000-2005 saw a dramatic shift away from PCC plans to MCO plans.

In February 2005, the Commonwealth received a 3-year renewal of the 1115 waiver. The terms of this waiver extension are compatible with the Governor's health reform proposal. The major changes will be phased in over the next year. These changes have the potential to dramatically affect the existing safety net providers as well as two MCOs. The waiver allows more flexibility for a range of possible approaches, especially for the Safety Net Care Pool. It is anticipated that over the next few months the Safety Net Care Pool Program design will be finalized. Services for mothers and children will be a key part of any solutions identified. Title V will stay at the table and be active in the design of the program, as well as developing the implementation plan so as not to disrupt current services and decrease access.

Health Services Delivery, Health Care Providers, and Shortages
Preventive and primary care services in Massachusetts are delivered almost exclusively in private practice or organized health care settings (e.g., staff model HMOs, community health centers and hospital outpatient departments). Massachusetts has an extensive and strong network of high quality, not-for-profit hospitals, and a community-based safety net system that provides primary and preventive health care services to MCH populations. Massachusetts also has a wealth of medical education and training programs, with four medical schools and three dental schools. There is no public delivery system of primary care for MCH populations. Title V and state resources have helped to support safety net providers at the community level for those unable to afford or otherwise access care.
The State continues to have a relatively large physician provider workforce, including primary care providers.
Despite the relatively large number of physicians both trained and currently registered within the State, as well as the extensive system of safety net health providers, localized health professional shortages remain in some urban and rural communities and for specific populations facing financial, linguistic or cultural barriers. Some of these disparities in distribution of health professionals result from the inability of community health centers (CHCs) and other safety net providers within these under-served areas to recruit and retain physicians. Physicians in Massachusetts continue to be negatively impacted by a high cost of living and malpractice insurance premiums. Massachusetts continues to lose obstetrical providers (including certified nurse midwives and family practitioners). The greatest losses occur in Level I facilities and those in Western Massachusetts. In May of 2005, one of two in-state nurse midwifery programs also halted admissions.

As in other parts of the country, health care employers are experiencing a severe shortage of nursing personnel. This shortage is affecting all aspects of the health system including hospitals, nursing homes, community health centers, home health agencies and schools. Additionally, there is a declining student nurse body and an aging-out of nursing faculty and staff. The University of Massachusetts has a fast track nursing program for individuals shifting from non-health careers in order to address the shortage issues; however, the results of this program will not be seen for several years.

An estimated 5,100 dentists have clinical practices in over 6,000 office locations. The overall ratio of 1,429 residents for every one dentist is higher than the national average. Although there is not an overall shortage of dentists in Massachusetts, disparities exist in access. The distribution of dentists is uneven, with a significantly higher concentration of dentists in the eastern third of the state. An

estimated eighty communities lack any dentist and additional communities do not have dentists who accept MassHealth. These communities are predominantly in the western and central parts of the state. Many of these are also the communities without community water fluoridation. A number of initiatives to increase access to dental screening and care have moved forward (see Safety Net Providers below).

The number of hospitals and hospital beds has been declining in Massachusetts for more than a decade. Currently 61 hospitals with licensed maternity units and two freestanding birth centers provide sufficient beds. Proposed new perinatal hospital licensure requirements will clarify levels of care. Pediatric beds have also declined, in part due to the declining need for inpatient hospitalization among children. Sufficient availability and distribution of specialized and tertiary pediatric services remain. However, children's hospitals nationwide are suffering financial problems and this is true in Massachusetts also.

To assure access, rural hospital services have been a major focus of both MDPH and the Massachusetts Hospital Association (MHA). Three Massachusetts hospitals have converted to Critical Access Hospitals (CAHs). These include Fairview Hospital in Great Barrington and the sole hospitals on Nantucket and Martha's Vineyard Islands. Two other hospitals are undergoing financial feasibility studies to assess the benefits of conversion to CAHs. The ability to qualify for this designation is essential because CAHs receive enhanced, cost-based, federal Medicare reimbursement to assist with maintaining the viability of local health care services in the more remote and less densely populated rural communities of the Commonwealth.

Community Health Centers and Safety Net Programs. As Massachusetts does not have a county- or city-based health services system, Community Health Centers (CHCs) along with a few remaining hospital outpatient departments serve as the key safety net providers. Low-income uninsured and underinsured, high-risk Medicaid recipients and other individuals facing barriers are able to access health care through a statewide network of CHCs regardless of ability to pay. CHCs are non-profit, community-based organizations that serve approximately 1 out of every 10 patients in the state. CHCs have experienced financial pressure due to numerous changes in the health care reimbursement and support environment.

Currently in Massachusetts, there are 19 Primary Care HPSAs, 15 Dental HPSAs, 5 Mental Health HPSAs and 44 MUAs. FQHCs receive automatic HPSA status from the federal Designation Bureau. Within the last year alone, 4 applications for new HPSA designations have been submitted through the PCO and are awaiting federal review: 2 Primary Care, 1 Dental and 1 Mental Health.

There are currently 58 safety-net dental clinics in Massachusetts located in community health centers, hospitals, schools, dental and dental hygiene schools and other community locations. All are MassHealth dental providers and have a sliding fee scale, and some provide free care under the state's compensated free care pool.
As part of Health Care Reform, Massachusetts' statewide system of community health centers has been designated "essential community providers." An assessment is underway of the capacity of CHCs to absorb increased patient enrollment and a profile of provider types that are key to service delivery redesign. As these redesigns unfold, with a concomitant redesign of MassHealth and uncompensated care pool funding mechanisms, it is expected that more community patients will be directed and linked to CHCs and other community based providers, particularly those providing behavioral health services. It is also anticipated that these providers will form the foundation for the state's new Safety Net program.

Providers of family planning services (primarily the MDPH and Title X grantees) have been very interested in the development of a Family Planning Waiver. The waiver would allow the state to expand eligibility for Medicaid covered family planning services, thereby increasing the availability of family planning services to low-income individuals, while supplementing (or supplanting) state-only funded programs. A positive CMS report found that Family Planning Waivers do avert births and are budget-neutral; they have been adopted in 19 other states. Currently, DPH and the Office of Medicaid

are meeting regularly to discuss the development of a waiver and there is also legislation pending that would mandate one.

There are approximately 2,100 school nurses in the state. School nurses act as a safety net and provide entry into the health care system as needed.

Rural Health Issues Absolute distances in Massachusetts are relatively short compared to many larger states. Yet rural and small town culture, a lack of resources such as transportation, and family and work-life needs make it difficult for many rural residents to travel to cities to receive services on a regular basis. Availability of primary care services in rural areas has improved in the past five years. Since 1997, three new CHCs have opened in rural areas and are currently opening satellite sites. Care for MCH populations is a significant component of the newly available services at each of these CHCs. The first free-standing federally certified and state licensed Rural Health Clinic (RHC) opened last summer in Dukes County. It serves as a safety net provider for the uninsured and underinsured on Martha's Vineyard. Feasibility of expanding this model to other areas is being explored.
Family planning clinics are located in some larger rural towns. Only limited services exist in more remote areas. New family planning and women's health services models are being explored for rural communities that build on the positive assets and community programs in these communities.

Special Needs Services and Shortages. In programs for Children with Special Health Care Needs (CSHCN), families, care coordinators and other providers report shortages of in-home providers of nursing and personal care attendant services. Families of children with autism report long waits and shortages of neurologists willing to accept children for diagnosis.

Early Intervention (EI) staffing shortages of therapeutic and nursing personnel are the most severe that have occurred since the full implementation in MA of the Individuals with Disabilities Education Act in 1993.
Public-Private Partnerships

The Massachusetts health delivery system depends on public-private partnerships for the delivery of all services, including MCH services. The vast majority of community prevention, primary care and specialty services are delivered by private health care providers and community-based non-profit organizations. Within each city and town, local government is responsible for developing and enforcing environmental and sanitary codes. Some larger health departments also provide screenings, public health and school nursing services, and other traditional public health core functions. MDPH contracts with a wide range of these providers (both private and public), using a competitive bid process, for most of its community-based services. All vendors with MDPH contracts must report on uniform performance measures that assure a culturally competent, family-centered, community-based approach. All are required to participate in the health improvement processes of their local Community Health Network Area (CHNA). MDPH also actively collaborates with local health departments to improve their infrastructures and provide training and technical assistance.

MDPH contracts not only with CHCs, but with a wide variety of other community-based health and human service agencies. These provide other MCH services such as early intervention, WIC, home visiting, teen pregnancy prevention, family planning, and health promotion. In addition, MDPH also purchases a broad network of HIV/AIDS and substance abuse services serving mothers, children and youth. Title V purchased services are integrated into MDPH primary care, school health, substance abuse, HIV/AIDS, tobacco control, and other CHC programs. This assures a multi-disciplinary, comprehensive, family-centered care model whenever possible. In areas of the state without CHCs, it becomes more difficult to provide comprehensive, multi-disciplinary services. The Bureau therefore works actively to support the development of additional CHCs or to promote access through networks of other community-based agencies and providers.

There are multiple instances of collaboration among insurers, private organizations, faith-based groups, and other state agencies such as public safety, education, and transportation. Success in maintaining and improving the health status of the residents of Massachusetts will depend on the

continual enhancement of these relationships.

B. AGENCY CAPACITY

The Bureau of Family and Community Health (BFCH), in the Center for Community Health, in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. MCH-related program areas within the Bureau are listed and briefly described in a table organized by the MCH Population Groups that they primarily address. This table is part of a Word document that is the attachment to this Part III, Section B (Agency Capacity) The table is called "BFCH MCH-Related Programs, Brief Descriptions, and Services Provided" and is the first 10 pages of the file.

The Bureau is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. The programmatic divisions through which the Bureau carries out it mission are described in the next section, "Organizational Structure."

TITLE V IN MASSACHUSETTS
The philosophy of the Massachusetts Title V program is that in order to fully address the health needs of mothers and children, systems, programs and services need to consider the health of the entire family, including the community. In the Bureau of Family and Community Health, all systems and programs begin with this philosophical approach -- addressing the needs of women, children and youth, including those with special health needs, within the context of the family. The state's philosophy simply stated is: "Healthy families lead to healthy children."

An attached Figure displays BFCH programs and activities schematically in relation to the levels of the "MCH Pyramid." This Figure is in the Word document that is the attachment to this Part III, Section B (State Agency Capacity); it is called "The MCH Pyramid Core Public Health Services Delivered in Massachusetts by MCH" and is the last page of the file. The pyramid includes the core public health services delivered by MCH agencies hierarchically by levels of service from direct health care services (the tip of the pyramid) to infrastructure building services (the broad base of the pyramid). The Figure lists both generic functions and services carried out by MCH agencies that BFCH provides or assures, as well as specific Massachusetts programs and initiatives. Many programs carry out activities at more than one level of the Pyramid (e.g. primary care service providers also assist families with enrollment in WIC or offer other enabling services as well; population-based lead screening programs also provide direct client case management for children found to be lead poisoned). However, for this purpose, each program has been shown only at the level of the Pyramid that represents its primary or dominant focus based on the MCHB definitions for levels of services. Within MDPH, the BFCH MCH programs work closely with the other components of the Center for Community Health (CCH) on a daily basis; these include the Bureau of Substance Abuse Services, the HIV/AIDS Bureau, the Massachusetts Tobacco Control Program, the Office of Multicultural Health, and the Office for Healthy Communities. The CCH, including its MCH programs, is closely connected within MDPH with such units as vital statistics, health statistics and evaluation, immunization, communicable diseases, and health care quality/licensing. The increasingly seamless integration of needs assessment, planning, program implementation, and evaluation can be seen throughout our 5-year needs assessment and the program activities and accomplishments described in this Application and Annual Report.
MDPH also collaborates as a sister agency within the cabinet-level Executive Office of Health and Human Services (EOHHS) with other state agencies in regular meetings, cross-agency program development, workgroups and special taskforces. Other agencies within EOHHS include the Department of Transitional Assistance (welfare), the state Medicaid agency, the Department of Social Services (child welfare), the Office of Child Care Services, the Department of Mental Health, the Department of Mental Retardation, Department of Youth Services, Commission for the Blind, Commission for the Hard of Hearing, and the Division of Health Care Finance and Policy. Agencies outside EOHHS with which we actively collaborate include the Department of Education and the Executive Office of Public Safety, and the new (as of July 1, 2005) Department of Early Education and

Care (DEEC). DEEC combines the functions of the Office of Child Care Services (OCCS) with those of the Early Learning Services Division at the Department of Education; the agency is to be responsible for the administration of all public and private early education and care programs and services in the state. Although no programs from MDPH were transferred to DEEC, MDPH staff have been involved in its establishment and expect to work in partnership to assure linkages and collaboration among birth to 5 services. The agency is supervised and guided by a new independent board. Massachusetts is trying to maximize systems building and minimize the potential confusion brought by multiple state plans, service networks, and community coalitions, by coordinating the development of these activities and structures across state programs.

The Associate Commissioner, Director, Center for Community Health, who is the Title V administrator, holds a senior leadership position within MDPH and is integrally involved in collaborations and decision-making regarding both internal and cross-agency program development that affects MCH populations. The Associate Commissioner also collaborates with and seeks input from professional organizations, consumer representatives, advocacy groups, and community providers, as well as participating on multiple committees and taskforces addressing MCH issues in the state.

Our MCH Priorities and State Performance Measures clearly reflect the systems development and partnership philosophies articulated above and have been developed with the Massachusetts health care system context in mind.

There are no statutes in Massachusetts directly related to the establishment or operation of a Title V program as defined by MCHB/HRSA. There are, however, a myriad of statutes and regulations that address issues related to MCH and CSHCN. Many of these have been referenced in the Needs Assessment section and in the NPM/SPM annual report narratives.

The Massachusetts Title V program has historically been a leader in the development of a statewide system of services that reflect the principles of comprehensive, community-based, family-centered care for CSHCN. An extensive review of where we stand on the MCHB-defined four constructs by which to assess the service system for CSHCN and state involvement with it is included in our Five-Year Needs Assessment (Section 2F3.4). A brief summary is presented here as well.

C. ORGANIZATIONAL STRUCTURE

The Bureau of Family and Community Health (BFCH) within the Center for Community Health in the Massachusetts Department of Public Health (MDPH) is the Title V Agency for the Commonwealth of Massachusetts. The Department of Public Health is part of the Executive Office of Health and Human Services. (See the organizational charts in the attachment to this Part III, Section C. (Organization Structure)). As part of a larger re-organization of state government, Governor Romney has implemented a major restructuring of the cabinet-level Executive Office of Health and Human Services, with the goal of being more responsive to providers, clients and communities by improving organizational efficiency, using technology more effectively to achieve coordination of services, and building on the current strengths in the system. Administrative cost savings are being achieved by eliminating duplication. Central functions such as legal, human resources, and information technology have been centralized at the EOHHS level. Four "offices" have been created within the EOHHS of which the Office of Health Services now includes Public Health, Mental Health and Health Care Finance and Policy. Title V remains within Public Health. The other three offices are the Offices of Medicaid; Children, Youth and Family Services; and Disabilities and Community Services.

The Commissioner of Public Health (Christine Ferguson) resigned in March and the EOHHS Assistant Secretary, Office of Health, Paul Cote was named Acting Commissioner. A new deputy commissioner was appointed in May. It is expected that a new commissioner will be named before the end of 2005. The Secretary of EOHHS has also recently resigned and a new Secretary, Timothy R. Murphy, was

just named in early July, 2005. Murphy is currently the Director of Policy in the Governor's Office and has been recently focused on the Governor's health care reform efforts. Further restructuring within EOHHS is being discussed.
As a result of reorganization within the Department of Public Health, Sally Fogerty, Massachusetts Title V director, was promoted to Associate Commissioner level and has leadership responsibility for the Center for Community Health within MDPH that includes the Bureau of Substance Abuse Services, the HIV/AIDS Bureau, the Office of Healthy Communities, the Office of Multicultural Health, and the Office of Tobacco Control, as well as the Bureau of Family and Community Health.

The Bureau of Family and Community Health reports to the Associate Commissioner, Director, Center for Community Health. The Center for Community Health continues a process of realignment begun in FY05 to improve both functioning and program integration, including modifications to the BFCH organizational structure (see below). The Title V programs remains within the Center. Currently Sally Fogerty is continuing to serve as the Bureau Director, as well as Center Director. Ron Benham, Director of Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN), is the state's CSHCN contact person.

The Bureau of Family and Community Health is committed to protecting and improving the health status, functional status, and quality of life of Massachusetts residents across the lifespan, with special focus on at-risk populations, low-income groups, and cultural and linguistic minorities. After organization changes during FY05, the Bureau includes five programmatic divisions:

-- Division for Perinatal, Early Childhood, and Special Health Needs (DPECSHN)
-- Division of Primary Care and Health Access (DPCHA)
-- Nutrition Division (including WIC)
-- Division of Health Promotion and Disease Prevention (DHPDP)
-- Division of Violence and Injury Prevention (DVIP)

The Bureau also includes the following Internal Support Centers:
--Applied Statistics, Evaluation, and Technical Services (ASETS)
-- Administration and Finance
-- Policy and Planning

In addition to its central office, the Bureau maintains staff in five regional offices. Many of these staff, such as FOR Families home visitors, and care coordinators for CSHCN provide direct services to individuals and families. Others work closely with BFCH programs, providing regional and local training and technical assistance, information and referral to services, coordination of services for families, performance monitoring, and other capacity building activities, such as the regional Early Intervention specialists. Among the staff are the Family TIES parent staff. Each regional office has a manager, under whose leadership staff work closely with communities to develop a system of care that is responsive to the diverse needs of community members. These staff facilitate the systems building activities in local communities for all Bureau programs and services.

D. OTHER MCH CAPACITY

As of June, 2005, approximately 257 persons (244 full-time equivalents) employed throughout the Department work on Title V programs; of these 152 (144 FTEs) are paid from Title V Partnership funds. The rest are paid from MCH-related accounts. Approximately 46 of the total are usually based in the MDPH regional offices or other off-site locations (such as physician practices); the others work out of our central office in downtown Boston. Due to the combined impact of state budget reductions on some of the Partnership programs, a round of Early Retirement incentives in FY04, and the transfer of CMSP and Healthy Start outside the Department, the number of staff paid with Title V Partnership funds, particularly those in regional offices, has been reduced over the past three years. It is expected to remain stable during FY06.

Brief biographical sketches of the Title V senior management team are available in the Word document attached to this section. The biographies are the first section of the Attachment. Key data capacity elements are summarized in Health Systems Capacity Indicator #09. (See Form 19.)

Not counting short-term positions and service on task forces, the Bureau employs over 16 parents who represent approximately 12 full-time equivalent staff. Flexibility in both work hours and locations has enabled us to hire and retain this large group of committed and skilled people. Family TIES Coordinators work out of the regional offices and are the voices behind the statewide 1-800 number for families with children with special health care needs. More information on our extensive parent involvement initiatives is provided through our reporting on Performance Measures. The multiple types of roles that they carry out are also displayed visually in a Figure included in the Word document attached to this Section. The Figure is the last page of the document.

E. STATE AGENCY COORDINATION

The BFCH views both intra-agency and interagency coordination as being essential to the achievement of its mission on behalf of improved maternal and child health. The Bureau maintains and promotes extensive networking and systems development relationships at the national, state, and local levels. These relationships include provider, non-profit, and other organizations; advocacy groups; coalitions, task forces, and community groups; other state agencies and governmental groups; universities and colleges; and internal MDPH working groups. Many of the activities carried out through these relationships are noted throughout the Annual Report and Annual Plan sections of this document as they related to specific performance measures or Title V priorities. The Bureau works with a broad base of constituency groups many of whom relate to specific populations or issues.

An extensive listing summarizing these relationships, categorizing them by type of agency/organization, is available in the Word document that is the Attachment to this Section. The following is a list of the major or key groups that the Bureau works with on MCH issues on a regular basis. See the attached file for details on relationships with public sector agencies, as well as a number of other private sector organizations and institutions.

Adaptive Environments
Conference of Boston Teaching Hospitals
Delta Dental Foundation
Disability Law Center
Federation for Children with Special Needs
Health Care Alliance
Health Care for All
Healthy Care Quality Partnership
Independent Living Centers
Jane Doe, Inc. (Massachusetts Coalition Against Sexual Assault and Domestic Violence)
Latino Grocer Association
March of Dimes
Massachusetts Chapter of the American Academy of Pediatrics
Massachusetts Food Association
Massachusetts Hospital Association
Massachusetts Law Reform Institute
Massachusetts League of Community Health Centers
Massachusetts Medical Society
Massachusetts Nurses Association
Massachusetts Public Health Association
Massachusetts School Nurses Organization

Massachusetts Society for the Prevention of Cruelty to Children
New England Coalition for Health Promotion and Disease Prevention (NECON)
New England Consortium (the successor to Project SERVE)
Project Bread
School-Based Health Center Association

Collaboration with Medicaid
With the restructuring of Medicaid at the state level over the last two years, the Bureau has established partnerships with the Office of Medicaid, Office of Acute and Ambulatory Care, Office of Long-term Care, MassHealth Operations, and the MMIS and Enrollment and Eligibility Components. In every Division and throughout a significant portion of its programs, the Bureau works with one or more of the offices or components within EOHHS that are responsible for a Medicaid activity. This continues to assure that there is a comprehensive and integrative approach in the outreach, enrollment and services provided to MassHealth, including CommonHealth, recipients. This includes involvement in waiver development, MMIS purchasing, enrollment functions and development of standards of care and quality initiatives. The Bureau strives to maximize Federal reimbursement mechanisms including FFP and municipal Medicaid opportunities.

F. HEALTH SYSTEMS CAPACITY INDICATORS

See Forms 17, 18, and 19 for Health Systems Capacity Indicators reporting and tracking data.

A number of the Health Systems Capacity Indicators are also being tracked closely by the Commonwealth through National Performance Measures, our State Negotiated Measures, or Priority Need areas. Information about the data trends and programmatic efforts to better understand and / or improve them can be found elsewhere in this Application. Information about activities related to our Priority Needs can be found in the Attachment to Part IV E (Other Program Activities). Those Indicators and their corresponding (or closely related Performance Measures) are listed below. In this transition year to new State Priority Needs and State Performance Measures, both current and new ones are referenced.

HSCI #01 (Hospitalizations for asthma, ages 0-4):
Current Massachusetts Priority Need # 9.
HSCI #02 (periodic screening of infant Medicaid enrollees):
Current SPM #0 3
New SPM # - none
[Note: HSCI #03 is not applicable to Massachusetts as all "SCHIP" infants are enrolled in Medicaid and are therefore reflected in HSCI #02.]
HSCI #04 (Adequate prenatal care using Kotelchuck Index):
NPM # 18
Current SPM # - none
New SPM # 09
Current Massachusetts Priority Need # 1.
New Massachusetts Priority Need # 1.
HSCI #07 (Medicaid dental services, ages 6 -- 9):
NPM # 09
Current SPM # 04
New SPM # 04
Current Massachusetts Priority Need # 3.
New Massachusetts Priority Need # 8.
HSCI #08 (SSI beneficiaries under 16 receiving rehabilitative services):
NPMs #02 - 06
New Massachusetts Priority Need # 3.
Note: All SSI beneficiaries in Massachusetts are automatically enrolled in Medicaid. The breadth of

the Medicaid benefit package in the state leaves Title V with no residual responsibilities because "the extent medical assistance for such services is not provided by Medicaid" is zero. To indicate the degree to which such services are available to the SSI population, the numerator is the same as the number of children on SSI.
HSCI #05 (Medicaid/non-Medicaid perinatal care indicators):
NPMs # 08, 15, 17, and 18
Current SPMs # 01, 06, and 08
New SPMs #01, 02, 03, 06, and 09
Current Massachusetts Priority Needs # 1, 6, and 10.
New Massachusetts Priority Need # 1, 2, 5, 6, and 7.
HSCI #06 (FPL covered by Medicaid, by age group):
Current SPM # - none
New SPM # - none
Current Massachusetts Priority Need # 6.
New Massachusetts Priority Need #- none .
Also see our Five-Year Needs Assessment and State Overview narrative in Part III. A. for updated information about Medicaid and other public insurance programs in the Commonwealth.
HSCI #09A, B, and C (MCH Data Capacity):
NPMs # 01, 08, and 12
Current SPMs # 01 and 08
New SPMs # 01, 02, 03, 05, 06, 09, and 10
Current Massachusetts Priority Needs # 1, 2, 4, 5, and 9.
New Massachusetts Priority Need # 1, 2, 3, 4, and 5.

Overall, the Health Systems Capacity Indicators illustrate that Massachusetts has a robust systems capacity across all MCH population groups and levels of the MCH Pyramid. Trend data (where shown) indicate little change in recent years. A number of the indicators (#02, 08, and many of the items in #09A, B, and C) are at their highest possible rates or scores and have been there for some time. Those related to data systems linkages and infrastructure (#09) have improved and, when not in place, are under active development. These initiatives now include PRAMS, PELL (Pregnancy to Early Life Longitudinal studies), and major database improvements and linkages through the Commonwealth's Virtual Gateway and ESM/EIM (Enterprise Service Management / Enterprise Invoice Management). See the narratives on our current Priority Needs #4 and 5 in the Attachment to Part IV. E. (Other Program Activities) for greater detail about these numerous data linkage activities.

Indicators related to pregnancy outcomes and to early childhood asthma continue to indicate need of improvement and are being addressed through a number of initiatives, federal grants, and partnerships with other public health colleagues, sister state agencies or programs, and/or private organizations and programs.

For two of the HSCIs, the quality or consistency of the data is worthy of note in looking at trends. The hospital discharge database (used for HSCI #01) remains in continuous change and improvement, with Observation Discharges and Emergency Room visits being added in recent years, but not for every data year. The multiple possibilities for capturing ICD codes at various levels (primary diagnosis, secondary, etc.) make these data more challenging to interpret over time than vital statistics. Our Asthma Planning grant is helping promote closer analyses. For HSCI #07, the reported percentage of Medicaid children and youth receiving any dental services continued to rise (64% in FY00, 73% in FY01, and 86% in FY02), before dropping significantly in FY03 to 46% and 48% in FY04. The increased rates may have reflected a number of positive changes: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives. The apparent drop, however, is due to a major correction in the data reporting methodology. Medicaid has informed us that the previous methodology overestimated rates of preventive dental services utilization. It does not appear that corrected data for previous years will become available, so trends should be analyzed from FY03 forward.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The overall health status and access to health care services of the MCH population in Massachusetts continues to improve. At the same time, there are some areas in which this generally positive progress has reached a plateau, or in which poorer outcomes have persisted. While improving overall, there continue to be significant disparities in outcomes and measures for some population groups. There are also some concerning trends to address: continued persistent health disparities, both geographic and population-based; increases in childhood obesity and asthma; the growing number of very low birth weight births; and the perinatal mortality rate. These trends require further analysis to better identify underlying contributing factors and develop strategies for improvement. Because of wide and growing coverage of health services through MassHealth and CMSP, relatively little Title V funding is expended on direct medical services. Rather, BFCH efforts are primarily focused on non-medical direct services, enabling, infrastructure and population-based services to further improve accessibility and coordination of services.

Direct health care and enabling services: The health care delivery system in Massachusetts can be characterized by four major trends that had implications for providing accessible, quality services to infants, children, youth, and pregnant women:
- increased health care costs
- increased cost of the uninsured (estimated currently at $1B annually)
- limits on insurer innovation due to the regulatory environment
- lack of transparency regarding both price and quality.

Financial access, however, is only the first step in assuring quality preventive services for mothers and children and children with special health care needs. Resources continue to be directed toward assuring the availability of comprehensive, community based, culturally competent services, with a strong network of safety net providers in the Community Health Centers and School Based Health Centers. This safety net does continue to be stretched severely due to inconsistent funding over the past several years. However, the FY06 state budget contains sufficient funding for Medicaid and safety net insurance programs. After an hiatus, collaborative outreach efforts by MDPH and Medicaid are being reactivated. Such major new initiatives as the EOHHS Virtual Gateway are also expanding information about and access to services for potentially eligible populations.

Through the medical home initiative, restructuring of care coordination services, and increasing work with private payers, a statewide system of care coordination, especially for CSHCN, is being developed. This system is a private-public partnership building on a broad range of services, agencies and programs that are resources to families. Other barriers to access to health care and related services continue to be cited by parents and other consumers, including flexibility in hours services are offered, lack of transportation, lack of providers who speak a language other than English (especially in mental health), and often a lack of knowledge of available resources. A lack of accessible providers continues to be an issue in oral health; reducing barriers to care is being discussed with growing interest as revenues improve.

Population based services: Over 99% of all newborns are screened for metabolic disorders, and parents are offered screening for 19 additional disorders and cystic fibrosis. Similarly, over 99% of all newborns receive newborn hearing screenings prior to discharge from a birth center or hospital. School based health centers and enhanced school services are two other mechanisms for delivering population based services that expanded through the early 2000's. Since 2003, they have experienced multiple state funding changes with a destabilization of the services. However, with more steady funding levels (while less than in the past), the system is regaining a new equilibrium.

Infrastructure building services: Collaboration and partnerships on the state and local levels have been historical and consistent priorities. The establishment and growth of the Community Health Network Area Coalitions brought new dimensions to this emphasis on partnerships. Numerous initiatives, programs, and new approaches to health and health systems issues have been successful as a result. The coordination and integration of the services system for at risk children from birth to

age 5, for example, has made great progress since our last needs assessment. Challenges remain, in particular with the successful transition of youth with special health needs to adult services, and improvements and strengthening of IT systems and data linkages to support efforts in all levels of the pyramid.

Status of Progress on Measures for FY04 Annual Report
The status of Annual Performance Objectives for Massachusetts is summarized below.
National Performance Measures (18 total):
5 Annual Performance Objectives -- No new data for FY04. These are the SLAITS measures (#02 - 06). Massachusetts scored better than national average for all but #06 (transition to adulthood)
10 Annual Performance Objectives Met or Exceeded (#01, 07, 08, 09, 11, 12, 13, 14, 15, and 17)
Of these, # 07, 08, 09, and 11 improved; #01, 12, 15, 17, and 18 were essentially unchanged (and fully met).
3 Annual Performance Objectives Not Met (# 10, 16, and 18), which got slightly worse. (The change in #16 and 18 were not statistically different from the target rates; both #10 and 16 are death rates with small numbers, subject to considerable variation from year to year.)

State Negotiated Measures (7 total):
5 Annual Performance Objective Met or Exceeded (#01, 03, 04, 08, and 10)
Of these, # 03, 04, 08 and 10 improved; #01 was essentially unchanged.
2 Annual Performance Objective Not Met (# 05 and 06)
The drop in #05 (smoking during pregnancy) may have been affected by major reductions in tobacco control funding.

B. STATE PRIORITIES

From its analysis of the Needs Assessment findings, Massachusetts selected the following 10 Priority Needs. These priorities are not listed in any "ranked" order; all are considered to be equivalent priority needs. The attachment to this section is a chart that summarizes the multi-faceted relationships among the new Priority Needs, National Performance and Outcome Measures, and the 10 new State Performance Measures (SPMs) that we are proposing. The new Priority Needs and Performance Measures address all MCH population groups and all levels of the MCH Pyramid. Most of the Priority Needs and many of the SPMs address issues that relate to all MCH populations and involve proposed actions at more than one level of the pyramid. As with our current set of SPMs, a number of the SPMs (4 out of 10) are composite measures, scored by unique scales. The Checklists for each of those four SPMs are also attached to this section, following the relationships chart.
We should also note here that one SPM (#08 for Massachusetts) is a "placeholder" for a childhood health and development asset-based measure to be finalized during FY06. Massachusetts and the five other states in Region I have been working with the National Center for Infant and Early Childhood Health Policy to develop an asset indicator framework and have agreed to develop an indicator that reflects the collective assets of their early childhood health and development systems. The Region has chosen to focus on their collective assets regarding child care health consultants (CCHC). [More details on this process and the rationale behind the approach may be found on the Detail Sheet for new SPM # 08.]

NEW: Priority Need #1: Improve the health and well being of women in their childbearing years.
A majority of overall pregnancy outcomes in the state continue to improve and are lower than the U.S. rates in many instances. However, the continuing racial and ethnic disparities in perinatal outcomes, and the rising VLBW and perinatal mortality rates are cause for concern and continuation of vigilant efforts in this area. BFCH recognizes that a woman's health status prior to becoming pregnant is a key variable in her pregnancy outcome. Health promotion activities, freedom from domestic violence, food security and good nutrition, access to primary care and family planning are all necessary components to overall good health to ensure a healthy family. A number of new state performance measures have also been selected to better target our approach and evaluate progress.

Priority Need #2: Improve adolescent health through coordinated youth development and risk

reduction.
Adolescent health risks have been well documented in the Needs Assessment. The majority of high school students engage in some risk behaviors that pose serious threats to their health and safety. Risk factors are similar for many behaviors. Students who engage in one high-risk or health-compromising behavior are often likely to engage in other risk behaviors as well; strong relationships have been documented between various adolescent risk factors and risk behaviors. This clustering of both factors and behaviors reveals the important interrelationships between one risk behavior (e.g. drinking) and other health consequences (e.g. automobile injuries, dating violence). On the other hand, factors often identified as "assets" or "resiliency factors" such as perceived adult support in and out of school, volunteer work, and other extra-curricular activities, are associated with lower levels of one or more risk behaviors.
Reducing risk behaviors and promoting youth development through all settings in which public health programs come in contact with teens are a major priority of the Department and the Center. A new, multi-pronged approach is being embraced through a new state performance measure.

Priority #3: Improve supports for the successful transition of youth with special health needs to adulthood.
Over 60,000 youth aged 14 to 17 in Massachusetts may need transition supports. Compared with other NSCSHCN-measured outcomes, transition stands out as problematic. Health professionals can play a critical role but nationally only 15% of respondents said their doctors provided guidance and support on transition. Massachusetts is in the same range, suggesting substantial room for improvement. The stakes for youth are substantial, given the relationships between disabilities, poor adult health, lower income, and other disparities.
The Massachusetts Consortium for CSHCN's Transition Task Force Background Brief summarizes needs, the current organization of services, strengths, and recommends next steps, noting the insufficiency and fragmentation of transition-related initiatives. Preparation for transition is complex because it is as varied and unique as the youth themselves. The adult health and human service system is ill equipped to "take on" young people with SHCN and lacks mandates. Pilot projects related to transition have taken place in MA and elsewhere and best practices are still being identified. A new 3-year MCHB grant will provide resources for a system-wide approach to the Priority Need.

Priority Need #4: Integrate service systems and data, and use data to inform practice.
BFCH has developed its capacity for electronic data collection and dissemination to a sophisticated level. To develop the most effective and properly targeted program services, time-sensitive, accurate information is essential. Much work still needs to be done to create truly comprehensive, timely, and flexible data systems and we continue with on-going innovation in this area.
Over the last several years, BFCH and MDPH began efforts to move to internet-based systems that would allow for the integration of data while assuring privacy for clients. More recently, EOHHS began a similar initiative and the MDPH and EOHHS efforts are now being fully integrated. The first stage of this system (known as the Virtual Gateway) began a year ago with the Information, Enrollment, and Referral component that uses a common application allowing an eligible individual to be enrolled in any state insurance program and referred to food stamps, child care, and WIC. Deployment of the more expansive DPH components -- including enrollment for other programs, service tracking, and electronic payments -- is expected to begin in January 2006. Other planned data initiatives include implementation of PRAMS, improved youth health surveys, and Center-wide use of logic models for programs.

Priority # 5: Increase capacity to promote healthy weight.
The rationale for addressing healthy weight as a Priority Need is self-evident. Massachusetts is very much a part of the national epidemic of overweight, obesity, unhealthy diets (low intake of fruits and vegetables), and inadequate levels of physical activity -- across the lifespan. The magnitude of the issue draws attention as do the potential health consequences, including diabetes, heart disease, and other chronic diseases, particularly with overweight starting early in life
The Needs Assessment presents many statistics addressing the scope and seriousness issues related to healthy weight, including health disparities. Many programs and opportunities for

intervention are in place, and policy/environmental interventions are also underway. They require ongoing support. The larger issue is system-wide capacity building, consistent messages, and approaches that continue to support local activities such as those articulated in our state plan. The roles of both health care settings and schools are particularly critical in promoting change. At the same time, improvements in key surveillance systems, could address major data and information gaps for the three priority MCH populations, allowing more timely and targeted interventions. A new, multi-pronged approach is being embraced through a new state performance measure.

Priority Need # 6: Develop and implement initiatives that address violence against women, children, and youth.
The adverse physical and mental health outcomes associated with exposure to violence, as either victim, witness, or perpetrator, underscore the need to integrate violence prevention into the range of maternal and child health initiatives. Gender-based violence (domestic violence and sexual assault), are particular risks for the MCH population. Domestic violence occurs in at least 25% of families in the U.S., and one in three female trauma patients is a victim of abuse. Approximately 20% of female public high school students in Massachusetts report being physically and/or sexually hurt by a dating partner. Adolescent girls who experience dating violence are at risk for other health risk behaviors including substance use, high-risk sexual behavior and suicidality. Studies dating back to the early 1990s have correlated domestic and sexual violence with chronic pain, HIV infection, gastrointestinal disorders, delayed entry into prenatal care, unintended pregnancy, smoking during pregnancy, and more. An increasing body of literature is detailing serious consequences for children who live in homes where there is violence. Data from the Adverse Childhood Experiences (ACE) study is demonstrating links between child abuse, domestic violence and sexual abuse and range of negative health outcomes as adults, including smoking, alcohol and other drug use, suicide attempt, chronic obstructive pulmonary disease, diabetes, and more.
MCH programs and providers are in an excellent position to identify victims of violence and to refer to appropriate resources. Education about domestic and sexual violence can assist providers in addressing these issues as part of routine service provision and can insure their awareness of community resources to provide linkages for clients. MCH can also play a critical part in such infrastructure roles as data analysis, policy development, public awareness and education, and capacity building.

Priority # 7: Increase the integration of unintentional injury prevention into relevant MCH programs.
Injury is the leading cause of death and disability for children and adults, ages 1-44. Every day in Massachusetts approximately 7 people die, 129 are admitted to a hospital and 1,918 seek hospital emergency department treatment because of an injury. Massachusetts children aged 0 to 17 experienced 187,323 injury-related Emergency Department (ED) visits in 2003 and total charges for these visits exceeded $122 million. Injuries were also responsible for over 4,030 hospitalizations among Massachusetts' children, costing over $15 million. Among women aged 18-44 in Massachusetts, injuries were responsible for 148,135 ED visits and 5,052 in-patient hospitalizations costing a total of $102 million and $16 million respectively. Significantly for the MCH population, in Massachusetts from 1990-2003 injuries cause 1/3 of all pregnancy-associated deaths and one in 7 pregnant women experienced a "pregnancy-associated injury."
Given that most injuries are highly preventable, these statistics underscore the need to intensify prevention efforts throughout the Commonwealth. Maternal and child health providers are in an excellent position to provide clients with injury prevention messages and strategies. Such messages can be routinely integrated into the work of providers with educational materials and appropriate referrals to resources. The recently developed DPH plan for injury prevention will help prioritize areas of unintentional injury and those strategies that have been proven most effective for prevention.

Priority # 8: Improve oral health.
Improvements in prevention and access to oral health care are critical needs for children and youth. Access to care for children covered through MassHealth continues to be a problem due to declining numbers of Medicaid-participating dentists. The state is currently considering an increase in rates and allowing dentists to limit the number of Medicaid recipients seen in order to increase participation rate. The availability of other safety net providers providing care to low income uninsured children is being

developed primarily through community health centers. Children with special health care needs, particularly the large number covered by MassHealth, have even more restricted access to care. A major concern is the lack of access for adults, especially pregnant women, since Medicaid eliminated all but emergency dental care for adults. Medicaid is involved in a class action suit related to access. Prevention services such as fluoride mouthrinse programs for children in non-fluoridated communities and sealants are not available statewide, although they are growing. Fluoridation efforts in several communities continue to face major challenges from anti-fluoridation groups.

Priority Need # 9: Develop and implement public health programs, policies, and collaborations that promote positive mental health.
Across many diverse BFCH programs, mental health needs among the MCH population and a lack of mental health service capacity have been identified as critical issues.
Over the past several years a Governor's Commission has been meeting to identify the major issues, barriers, and gaps in services and to develop a plan for addressing the complex issues related to providing access to services and decreasing the number of children who remain stuck in residential services or hospitals due to lack of resources. It is expected that the recommendations will be finalized by September 2005.
The Medicaid Behavioral Health Program was transferred to the Department of Mental Health (DMH) in 2004. Recognizing the need to develop a more accessible and responsive system, including services for children and youth, the DMH is just completing a strategic plan. The Title V program will be working with DMH to continue to identify joint areas of focus and how public health programs can support and enhance mental health services.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	100	100	100	100	100
Annual Indicator	100.0	100.0	100.0	100.0	100.0
Numerator	82703	106	109	124	100
Denominator	82703	106	109	124	100
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	100	100	100	100	100

Notes - 2002

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at

the University of Massachusetts Medical School. The data are for Calendar Year 2002. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Massachusetts screens every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), “Maple Syrup” Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2002, the total of 104 confirmed cases receiving treatment included 4 with PKU, 55 with Congenital Hypothyroidism, 38 Hemoglobin Disorders, 2 Congenital Toxoplamosis, 1 Biotinidase Deficiency, 4 MCAD.

We have modified previous data using the new definition of this measure for 2001; the panel of mandatory tests has not changed over that time.

Notes - 2003

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2003. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Massachusetts screens every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), “Maple Syrup” Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2003, the total of 124 confirmed cases receiving treatment included 3 with PKU, 60 with Congenital Hypothyroidism, 2 Galactosemia, 44 Hemoglobin Disorders, 1 Congenital Toxoplamosis, 8 Congenital Adrenal Hyperplasia, 6 MCAD.

Notes - 2004

Data on Newborn Screening from the New England Newborn Screening Program (NENSP) at the University of Massachusetts Medical School. The data are for Calendar Year 2004. The NENSP provides all these newborn screening services and furnishes these data. See Form 06 and its Notes also. Massachusetts screens every newborn for ten disorders: Phenylketonuria (PKU), Congenital Hypothyroidism (primary), Galactosemia, Hemoglobin Disorders (including sickle cell anemia), “Maple Syrup” Urine Disease (MSUD), Homocystinuria, Congenital Toxoplasmosis, Congenital Adrenal Hyperplasia, Biotinidase Deficiency, and Medium-chain acyl Co-A dehydrogenase deficiency (MCAD).

Every newborn with abnormal results is tracked to a normal result or appropriate clinical care. In 2004, the total of 100 confirmed cases receiving treatment included 2 with PKU, 52 with Congenital Hypothyroidism, 2 Galactosemia, 31 with Hemoglobin Disorders, 1 with Congenital Toxoplamosis, 3 with Biotinidase Deficiency, 5 with Congenital Adrenal Hyperplasia, and 4 with MCAD.

a. Last Year's Accomplishments

Individual, manual cross-checking activities in cooperation with participating nurseries continued in 2004, to assure specimens were received from all babies. Efforts continued to obtain satisfactory specimens from all babies from whom at least one unsatisfactory specimen was received. Any remaining babies were extensively tracked and efforts documented.

The Integrated Systems for CSHCN project implemented a process with the NENSP that adds specific language to the fax form sent to inform physicians of an out-of-range blood screen for an individual newborn. This notification routinely informs the physician of the Community

Resource phone line for referring these infants and their families to EI, EIPP, Care Coordination, Family TIES and technical assistance.

The Newborn Hearing Screening Program utilized EI data to ensure that children identified with hearing loss were enrolled in EI services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Routine screening of all newborns for 10 treatable disorders			X	
2. Optional screening for 19 additional metabolic disorders and cystic fibrosis			X	
3. Tracking of every newborn with abnormal results to a normal result or appropriate clinical care				X
4. Regular quality improvement activities to assure all babies are screened and tracked				X
5. BFCH and NENSP collaboration to assure ongoing linkages of families to comprehensive services				X
6. Work toward improved integration of genetics and newborn screening				X
7. Through regional collaboration, address newborn blood and hearing screening issues for “border babies”				X
8.				
9.				
10.				

b. Current Activities

All newborns have blood spot specimens collected before hospital discharge and sent to the New England Newborn Screening Program (NENSP). Babies with initially unsatisfactory specimens elicit a telephone contact within 24 hrs notifying parents of the need for follow-up. The baby is flagged in the database to appear on a repeat specimen required list, and automatically unflagged when the repeat specimen is logged in. Staff monitor this list weekly and track and follow-up babies from whom repeat specimens do not arrive. Every newborn with abnormal results is tracked to a normal result or appropriate clinical care.

As part of ongoing quality assurance, electronic files are submitted to the NENSP from a selected hospital NICU, Community Health Center, and pediatric practices with data on all babies either in their nursery or being seen in their pediatric practice. These files are electronically matched to specimens received: non-matched babies are reported back (to get specimens).

Staff of programs in the Division of Perinatal, Early Childhood Health and Special Health Needs meet with New England Newborn Screening Program (NENSP) to maintain and strengthen the linkage between NENSP and BFCH programs, especially Care Coordination for CSHCN, Early Intervention (EI), and the Early Intervention Partnerships Program (EIPP) to assure follow-up of families of identified newborns and linkage to service. BFCH program staff also meet regularly with this advisory committee to assist in policy development and explore ways to increase the linkage of genetics diagnostic centers with the NENSP and BFCH programs for families of children with identified conditions.

BFCH staff participated in the New England Regional Genetic Group (NERGG) annual meeting and one staff member is on the NERGG board. BFCH staff co-chair the New England Public Health Genetics Education Collaborative and NERGG's Education Committee, which (as part of a HRSA regional genetics grant) is conducting a genetics education needs assessment.

Two BFCH staff have also been asked to participate in the Benchmarks for Fairness in Expanded Newborn Screening for Metabolic Disorders coordinated by the New England Regional Genetics and Newborn Screening Collaborative. The Benchmarks for Fairness is an evaluation system focusing on equity, efficiency, and accountability and that looks to assess fairness in newborn screening reform. The end product will be the development of an interview and data collection model tied to the Benchmarks for Fairness. First meeting held on 1/21/05.

c. Plan for the Coming Year

Current on-going activities will continue from FY05.

As part of a new federal grant, DPH will develop and implement a Statewide Screening and Intervention Plan to assure children receive early and continuous screening and those with identified risks receive services. This will include children identified through the newborn blood screening program. The focus of the Plan will be to develop and document systems for collecting and integrating screening data and to provide outreach to families.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				64.4	65
Annual Indicator			64.4	64.4	64.4
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	70	70	70	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. No new state-level data for 2004. The 2004 indicator is based on the State estimates from SLAITS.

a. Last Year's Accomplishments

Through the Family Initiatives Program, family members received stipends and mentoring to participate on DSHN advisory committees and completed evaluations on how/whether skill building activities and participation opportunities helped them in other areas of their lives. Fifty of the parents indicated interest in becoming advisors to MDPH in areas such as MCH Block Grant, programmatic development and outreach.

In March 2004, a restructured DSHN created a statewide Community Support Line staffed by Community Resource Specialists for families with special health needs to improve access to information, referral and technical assistance. (Provided 215 calls to parents in the 4th quarter of FY04.)

To provide flexible supports to meet family identified needs and enhance community participation, over 200 parents of CSHCN through focus groups and surveys consulted in the development of a state mandated "Family Support Plan."

The Family TIES project received 1,941 calls and 63,000 hits on its redesigned website, distributed 2800 brochures in English, Spanish and Portuguese, 1500 Resource Directories, several hundred tip sheets on a range of topics, and developed and disseminated a project newsletter to over 300 families.

Family TIES co-sponsored the annual statewide parent/professional conference "Visions of Community." Over 600 parents attended and were surveyed to look at their level of knowledge about emergency preparedness. Survey feedback helped in the development of emergency health care plans and regional and statewide preparedness initiatives.

The Early Intervention Parent Leadership Project (EIPLP) toll free line received 437calls, disseminated 6 additions of the project newsletter "Parent Perspective" to over 800 parents and professionals, and developed a "welcome" newsletter available in Spanish and English for new families entering the EI system. Staff participated on ICC committees and provided resources and training at many statewide conferences.

Staff from both projects participated in Mass Consortium for Children with Special Needs activities and exhibited at the June 2004 meeting.

Family Initiatives collaborates with the Mass Chapter of Family Voices to maintain a listserv for the exchange of information/support among parents of CSHCN and the professionals serving them.

Parent Information Kits were distributed to approximately 900 parents of children with hearing loss and to professionals.

Over 12 parents assisted in the development of the 2nd edition of Directions: Resources for Your Child's Care, a resource manual/record-keeping tool for families.

The SSI Public Benefits program provided technical assistance, information and referral calls to 147 parents (almost a 50% increase); increased the number of parents who applied for benefit;

and increased the number of 'peer advocates' to assist families in navigating public benefits and services systems. Training programs included approximately 78 parent participants (up from 36 the year before).

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Extensive family participation in CSHCN programming through Family TIES and EI Parent Leadership				X
2. Family members/consumers hired as paid staff/consultants to the state CSHCN programs				X
3. Parents actively participate in multiple advisory groups				X
4. Parent leadership support and training is provided, including stipends				X
5. MA Medical Home Project provides increased opportunities for parent-professional partnering				X
6. Training on SSI/public benefits systems presented directly to parent groups				X
7. Telephone technical assistance, information, and referral provided to parents and providers of CSHCN				X
8. Parents participate in School Health Advisory Committees required in the ESHS program sites				X
9.				
10.				

b. Current Activities

The Director of Family Initiatives participates in interagency collaboration to support emergency preparedness initiatives for CSHCN and their families; co-chairs the Family Participation Working Group of the Consortium for CSHCN; serves on Title V Five-Year Needs Assessment Steering Committee; serves as chair of the Family Involvement subcommittee for the Massachusetts Early Childhood Comprehensive Systems Grant and participates in the development of a new statewide system of complex care management ensuring the primary role of family centered approaches to complex situations.

Training programs on SSI/public benefits systems are presented directly to parent groups and parent leadership organizations to empower parents to negotiate for benefits and services for their children. The Community Support Line provides telephone TA, information on Care Coordination services, referrals, family supports and other resources to families and providers.

Parents and consumers participate in the UNHSP Advisory Committee and recommend program policies and procedures. Parent Outreach staff provide support, including Parent Information Kits for families with newborns and young children with hearing loss.

The Newborn Hearing Screening Program disseminated surveys to approximately 3,250 families to assess satisfaction with newborn hearing screening and intervention. [See NPM # 12 for more details.]

A new EIPLP structure has given parent staff more hours to outreach to families and provide information about the EI system. In new Focused Monitoring efforts staff measure family satisfaction and effectiveness of the system by piloting satisfaction surveys developed by the

National Center on Special Education Accountability and Monitoring Center and through the involvement of parents as team members in program re-certification.

Family Initiatives recruits, trains and mentors parents to take roles on the Interagency Coordinating Council. Families are active participants on ICC committees and provide valuable input into Block Grant development and review.

Working with an evaluator from the BU School of Social Work, Family TIES implemented a program evaluation. Data collected from this on-going initiative will be used to modify and improve services and make them more responsive to family needs.

A first printing of the Directions manual is available on the DPH website and has been distributed to care coordinators and all MA pediatricians. [See NPM # 3 for more details.]

School-based Health Center (SBHC) standards address accessible services and parent satisfaction. The new RFR required that all "provide effective care coordination for all SBHC users and all enrolled CSHCN based on written individualized care plans."

MassCARE families participate in decision-making services and activities through site visits, focus groups and satisfaction surveys. Consumers also are paid program staff.

c. Plan for the Coming Year

Individual and regionally based plans for emergency preparedness for CSHCN and their families will be in place with on-going communication and collaboration facilitated by Family Initiatives and the DPH Special Populations Coordinator. Staff of Family TIES will support families to participate in these regional collaborations and develop resources to assist with individualized planning.

Family TIES coordinators will support DPH care coordinators in community based pediatric practices with non-clinical I & R and mentoring for families of CSHCN.

Family Initiatives will take a lead role in formally bringing together parent leaders for information, education and support functions. The Director will also work closely with Directors of Community Support and Care Coordination to ensure a collaborative, family centered process.

As part of a new federal grant, DPH will contract with New England SERVE and the MA Consortium for CSHCN to create a Family-Professional Partners Institute (FPPI). The FPPI will serve as a broker, bringing together families and organizations to take on a variety of partnering roles (such as focus group participants, program planners, consultants, advisors, and committee members). The Institute will provide training and mentoring for family partners and technical assistance and support to organizational partners. It will articulate to both family members and organizations the value of partnerships and will identify potential areas of partnership and the steps for achieving these partnerships.

Staff of EIPLP will expand training component of project activities to ensure broad dissemination of educational and skill building opportunities for the EI Community.

The Newborn Hearing Screening Program plans to analyze and report on the results of the Family Satisfaction and Primary Care Clinician surveys.

Family satisfaction with and use of the Directions resource manual will be evaluated by conducting surveys and focus groups.

SBHC staff will conduct site visits that include medical chart reviews to assess quality of individualized care plans.

Call volume on the statewide Community Support Line for CSHCN will continue to increase. The Public Benefits program will expand the linkage of public benefits training and resource staff to other area hospitals.

A pilot client/parent satisfaction survey will be implemented in a sample of the Essential School Health Services program sites.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				61	65
Annual Indicator			61	61	61
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. No new state-level data for 2004. The 2004 indicator is based on the State estimates from SLAITS.

a. Last Year's Accomplishments

Care coordinators were assigned to 6 new pediatric practice sites, bringing to 18 the total number of Medical Home practices. Evaluation began with the practice sites.

Care Coordinators developed a tool for communicating with the primary care practices (PCPs) about children with special health needs referred for services.

EIPP Nurses, Social Workers, and Family Liaisons developed formal linkages with medical providers and birthing hospitals, ensuring continuity of care. The MCH Nurses provided comprehensive health assessments with linkages to primary and specialty health care providers and referrals to community based services for the 393 women and 260 infants served in FY04.

A second edition of Directions: Resources for Your Child's Care, a resource manual and record-keeping tool for families of CSHCN, was updated, edited, and redesigned in collaboration with the Alliance for Health Care Improvement and the MA Consortium for CSHCN. Directions includes expanded information for families about medical home.

Approximately 62% of CSHCN aged 1-18 who were seen at least once at a School-based Health Center reported having a medical home. Retrospective chart abstractions were evaluated in terms of the quality and clinical appropriateness of the information exchanged between primary care providers, parents and SBHC staff.

103 Essential School Health Service Programs (representing 551,184 students) referred a total of 179,752 students requiring care to their primary care providers. Of these, 12,324 were students without primary care providers who were then linked to providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Care Coordinators for CSHCN are housed in primary care practices and get referrals from the practice and community sources		X		X
2. Medical Home Networking Project and other collaborations with MA Consortium for CSHCN promote the concepts of medical home as the standard of care for this population		X		X
3. All BFCH programs serving children screen/refer for a regular primary care provider		X		
4. EI and other programs are charged to maintain effective coordination and collaboration w/child's medical home		X		X
5. Integrated Systems for CSHCN links newborn screening and follow-up w/care coordination and medical home		X		X
6. Collaboration with MCOs, including Medicaid, to promote medical home concept				X
7. MassCARE offers care coordination services and links to primary and specialty care to all enrolled children with HIV		X		
8. Systems/coordination among programs (MASSTART, Medical Review Team, Catastrophic Illness, and Community Resource Unit) to link CSHCN with care coordination and medical homes				X
9. Distribute “Directions: Resources for Your Child’s Care” to families of CSHCN and providers, in collaboration with Alliance for Health Care Improvement and MA Consortium for CSHCN				X
10.				

b. Current Activities

Care coordinators for CSHCN work in 18 pediatric primary care practices across the state and

help primary care physicians design, family-centered care plans and establish focused, streamlined office systems to improve the quality of care. They develop tools for identifying and referral of CSHCN and are developing regional resource guides. They help families optimize insurance coverage, access public benefits, find parent to parent support, and become better advocates. They attend school meetings and facilitate aspects of youth-to-adult transition.

The Care Coordination Director and staff participate in the Care Coordination, Medical Home, and Transition workgroups of the MA Consortium for CSHCN. The Directors of Family TIES and the DPECSHN are members of the Consortium Steering Committee and participate in the Champion Grant and the Stringing the Pearls project.

Family TIES surveys families about their understanding of medical home concepts and requests referrals to physicians currently providing elements of medical home.

FIRSTLink, MASSTART, Medical Review Team, Catastrophic Illness in Children Fund, and FOR Families programs assess whether CSHCN have a medical home and make referrals as needed. FOR Families staff follow up to ensure that the referral is active and ongoing.

The EIPP and FIRSTLink have formal linkages with medical providers and hospitals for continuity of care. MCH nurses and social workers ensure that enrolled children and families receive comprehensive health assessments, linkage to primary and specialty health care providers and referrals to community-based services.

10,000 copies of Directions are being printed and distributed to families receiving MDPH Care Coordination and EI Regional Consultation services and other families of CSHCN. To help ensure that families receive information or a copy of the manual directly through their PCP, each pediatrician member of the MA Chapter of the American Academy of Pediatrics will receive a copy. Directions is or will be available on the MDPH website in English, Spanish, Portuguese and Haitian-Creole.

UNHSP verifies that each newborn/family is linked to a PCP and helps with access and referral. AAP is represented on the UNHSP Advisory Committee and provides feedback on program guidelines and activities. The program, assisted by Jane Stewart, MD, conducts outreach to primary care clinicians serving families with children with hearing loss.

School health programs and SBHCs working with the Executive Committee of School Physicians (ECSP) work to strengthen the communication between students, family, and PCPs. ESHS/SBHCs require that students be assessed/referred for health care and health insurance. The School Health Unit, with the ECSP and the AAP has developed a physical examination form that is part of the school health record.

MassCARE offers care coordination and links to primary/specialty care for children with HIV.

c. Plan for the Coming Year

Family TIES staff will work directly with Care Coordinators to recruit and mentor families to develop Family Advisory Councils at the pediatric primary care practices.

Care coordinators will work with practices to increase the number of CSHCN referred to care coordination, Family TIES, and other services.

The use of Directions by families and providers will be evaluated by conducting surveys and focus groups. Data collected about its users and use will be used to secure additional funding from the Alliance for Health Care Improvement for future printings of Directions.

As part of a new federal grant, DPH will collaborate with the MA Chapter of the American Academy of Pediatrics (MCAAP) and the MA Consortium for CSHCN to enhance medical provider capacity for providing medical homes to CYSHCN. Activities are aimed at increasing general knowledge about medical homes and educating physicians-in-training about caring for CYSHCN through a medical home. Activities will include adapting the MA Medical Home Network Project's curriculum and identifying opportunities for presenting segments of the curriculum to physicians in community continuing education forums and conferences; designing communication and training activities in collaboration with the MCAAP; and developing a summary of "best practice" medical education curricula; and reviewing tools used for identification and screening of CYSCHN and making recommendations to the MCAAP about the most effective tools to use in primary care pediatric practices in MA.

DPECSHN will expand parent-to-parent support for families of CYSHCN receiving their primary care in practices where DPH Care Coordinators are placed, thereby increasing practices' capacity to provide a medical home to CYSHCN and their families. Family TIES parent coordinators will provide additional support to families in these practices. Through greater Family TIES involvement, practice staff will gain expanded knowledge of community resources that can be shared with families, and will increase their awareness of the varied contributions that family members can make to help practices be more responsive to families of CYSHCN.

School Health will disseminate the newly developed physical examination form completed by the PCP prior to entry into school, every 3-4 years after, and annually prior to participation in competitive sports.

The newly revised Comprehensive School Health Manual will have updated chapters on (1) school health as part of a total system of care for children (emphasizing the new school physician role template, which focuses on the school physician as a liaison to the community providers and collaboration with primary care providers) and (2) care of children with special health care needs.

The new preschool vision screening guidelines will be shared with primary care providers. Both school nurses and PCPs will be invited to the training sessions organized in collaboration with the Mass. College of Eye Physicians and Surgeons.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				65	65
Annual Indicator			65.1	65.1	65.1
Numerator					
Denominator					
Is the Data					

Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	65	70	70	70	70

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. No new state-level data for 2004. The 2004 indicator is based on the State estimates from SLAITS.

a. Last Year's Accomplishments

The SSI and Public program provided 20 training programs on public health insurance benefits to 421 participants. Training participants included hospital resource specialists, social workers, patient care coordinators and financial coordinators, as well as Parent Leaders of a Parent Initiative and a Family Leadership organization.

Through the newly enhanced and expanded Community Resource line, staff responded to 431 technical assistance requests by telephone and email and sent mailings to families upon request with information and applications for public insurance programs. [These numbers are for the fourth quarter of the year only!]

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. All BFCH programs screen/refer for health care access and insurance coverage		**X**		
2. SSI benefits, community support, and technical assistance program provides trainings on eligibility, application process and appeals		**X**		**X**
3. State law mandates health care plans to cover newborn hearing screening and diagnostic follow-up		**X**		
4. The Special Medical Fund pays for selected services not covered by insurance		**X**		
5. The Catastrophic Illness in Children Relief Fund pays for medical expenses not covered by insurance	**X**	**X**		
6. Care Coordination for CSHCN provides assistance w/accessing and optimizing health insurance benefits		**X**		
7. Care Coordinators work with families and providers to make community based services more family friendly and accessible		**X**		**X**
8. Care Coordination Program's Hospital Initiative provides TA and liaison to tertiary hospitals, assisting staff with referrals and d/c planning for infants and CSHCN		**X**		**X**

9.				
10.				

b. Current Activities

It is a mandate for all BFCH programs that have direct contact with children and families to screen for health care access and insurance coverage, and make referrals and provide assistance with enrollment and access as appropriate to the program and the family. In particular, SSI and Public Benefits Outreach, Care Coordination, EI, EIPP, FIRSTLink, school health and school-based health centers, FOR Families, and community health center based programs are key venues for this activity. The largest single service to families by Care Coordination for CSHCN is assistance with accessing and optimizing health plan benefits.

Additional support for non-reimbursed expenses above or in place of insurance is available to families of CSHCN through the Special Medical Fund and the Catastrophic Illness in Children Relief Fund. Care Coordinators assist over 600 eligible families annually using the SMF, reimbursing costs of goods and services related to raising a child with special health care needs. The CICRF can provide direct funding to families whose insurance is inadequate to cover their medical expenses.

The Community Resource line assists families with information and technical assistance about public insurance programs they may be eligible for, including MassHealth, CommonHealth, Kaileigh Mulligan, and about the Catastrophic Illness in Children Relief Fund for possible eligibility to cover out-of-pocket expenses.

Family TIES coordinators provide information to parents and providers about insurance options, changes in programs and eligibility. Family Initiatives and Family TIES partner with Massachusetts Family Voices to disseminate information and train families about options.

The SSI Benefits program provides training on eligibility, application process and appeals for SSI, CommonHealth, Kaileigh Mulligan Home Care, and MassHealth to DPH Care Coordinators, hospital social workers, EI programs, health care providers, parent organizations, school personnel, state agencies, human service and advocacy agencies who help families in applying for benefits that include public insurance and managed care networks. An annual mailing of updates on SSI eligibility criteria is made to over 500 key contacts, including pediatric primary health care settings.

SSI Benefits staff participate in bi-weekly meetings of the Children's Health Access Coalition, which continually assesses the percent of the population receiving adequate health coverage and actively monitors the effect of health insurance reform on groups including CSHCN. Staff also regularly participate in quarterly meetings of the Covering Kids and Families Coalition, which monitors and assesses the effect of federal and state health insurance reform on children, especially CSHCN.

Community outreach and care coordinators have established linkages to Medicaid long-term care programs and the Kaileigh Mulligan program.

c. Plan for the Coming Year

Current on-going activities will continue from FY05. Continue to assure current levels of coverage.

Actively participate in design of Governor's health care reform package, including the development of the safety net care program.

Continue to enhance and further strengthen linkages and referral processes for CSHCN in SSI,

Kaileigh Mulligan, and CommonHealth with the long-term care components of Medicaid that are now located in the Executive Office of Elder Affairs (EOEA).

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				79	80
Annual Indicator			79	79	79
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	80	81	81	81	81

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. No new state-level data for 2004. The 2004 indicator is based on the State estimates from SLAITS.

a. Last Year's Accomplishments

The Massachusetts Consortium for CSHCN, of which DPECSHN staff are members of the Steering Committee and workgroups, launched a new workgroup on Family Participation.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintenance of the SSI/Public Benefits Outreach and Training Program		X		X

2. Care Coordinators for CSHCN work in several large pediatric primary care practices across the state		X		X
3. Care Coordinators in regional offices for CSHCN who are outside the designated primary care sites		X		
4. Community Support Line provides technical assistance and referral regarding service systems to families and providers		X		X
5. Technical assistance to families and schools allows medically complex CSHCN to attend public school		X		X
6. Active staff participation in the MA Consortium for CSHCN and its Steering Committee				X
7. Active staff participation in New England Regional Genetics Group and NE Consortium of Metabolic Programs				X
8. MassCARE offers a community based system of care for infants, children, and adolescents with HIV and their families		X		X
9. Families are surveyed to assess satisfaction with primary care and issues for quality improvement				X
10. Families receive training and support to participate in policy development, program planning, implementation, and evaluation				X

b. Current Activities

Family Initiatives, Family TIES and the EIPLP provide information and support to families to partner with community-based service systems including EI programs. Essential Allies training is offered to EI programs and community-based agencies.

Through the MASSTART program, 4 specialty providers are funded to provide consultation and training to families and school personnel statewide, allowing medically-involved, often technology-dependent children to attend public school. School personnel are trained on how to understand and meet the special needs of individual children and adolescents. Contracted vendors assist families and schools with developing Individualized Health Plans and Emergency Plans for school, to be incorporated into IEP of children who are medically-complex or technology-dependent. They also provide information, referral and community resources concerning services for children and adolescents assisted by medical technology and facilitate family linkages with care coordinators and other Division programs.

Families applying for Medical Review Team and Catastrophic Illness in Children programs are evaluated for referral to care coordination.

School-based Health Center standards include a Continuity of Care standard that specifies that SBHCs develop a collaborative relationship with students, their families, school health programs, and other health care providers in the child's community. SBHCs must also develop written policies to obtain student and/or parental consent to share information regarding the student's health care. An Access Standard specifies that SBHC services must be easily accessible and designed to eliminate or diminish barriers to care for students and to participation by parents or guardians. Additional sub-categories of standards include the requirement to administer a student survey to obtain feedback on satisfaction and the need to accommodate working parents.

MassCARE offers a community-based system of HIV specialty care throughout the state, with 8 community service systems and 3 regional perinatal centers. Services include primary and specialty care, access to clinical trials, support groups, and a network of activities for families.

Participate in Children's Mental Health Commission to develop recommendations to increase

access.

Participate in the Peer Review Team (PRT), an EOHHS-wide children's services mechanism to resolve "stuck cases" that cross state agency boundaries or present other unique service needs.

See also NPMs 2, 3, and 4

c. Plan for the Coming Year

Current, on-going activities will continue from FY05.

The Family Initiatives program will partner with a number of family organizations to raise the awareness of community-based systems of care to the principles of family-centered care. This increased awareness will assist community providers to make services more responsive to family needs and thus increase family satisfaction.

The Center for Community Health and the Division for PECSHN will participate in the further design of the EOHHS Communities First initiative to assure the children are included in all program components.

The Division for PECSHN will continue to link all programs for CSHCN in order to facilitate each family's receiving referral to needed services from any point of entry into the system.

The School Health Unit Director and a representative from the Executive Committee of School Physicians will present at the annual Children's Hospital Medical Center conference in November 2005. The focus will be on enhancing collaboration between primary care providers and school health service programs.

See also NPMs 2, 3, and 4

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				5.8	10
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**

Annual Performance Objective	10	10	10	10	10

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are pre-populated with the data from 2003 for this performance measure. No new state-level data for 2004. The 2004 indicator is based on the national estimate from SLAITS

a. Last Year's Accomplishments

DPECSHN staff served on the Mass. Consortium for CSHCN Transition Task Force, which developed a Background Brief on transition issues for youth with special health care needs in Massachusetts, including recommendations for ways in which to improve transition outcomes.

The Abstinence Education Program produced three brochures targeting parents and youth that address sexuality, exploitation, and abstinence. The program ensured availability and access of education materials and collateral items for youth and their families with special health care needs

Care coordinators distributed abstinence education brochures for CSHCN to youth, families, and providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. SSI/Public Benefits program provides resources and training for agencies serving transitional youth				X
2. Telephone/email technical assistance is provided to agencies serving youth in transition		X		X
3. Workshops provided for families on health care transition through Family Initiatives		X		
4. Care Coordinators offer formal and informal training on youth-to-adult transition (Eng and Sp.)		X		X
5. SBHC programs for teens w/chronic health problems and all ESHS nurses foster responsibility and self-care		X		
6. Participation in Transition Work Group of the MA Consortium for CSHCN				X
7.				
8.				
9.				
10.				

b. Current Activities

The DPECSHN Director of Special Projects is an active member of the National Disability

Mentoring Council, a federal grant to Partners for Youth with Disabilities (PYD) to promote mentoring programs for youth with disabilities across the nation.

Through a CDC grant, DPH contracts with Boston University to form the Massachusetts Health and Disability Research Partnership (MHDRP), to develop resources to assess transition to adulthood for young people with disabilities. Three grant proposals have been submitted to conduct a longitudinal study, recruiting adolescents from an urban health plan and the Massachusetts Hospital School. MHDRP established a Massachusetts Transition Advisory Board (M-TAB), a 17-member consumer group to advise on this project and related issues/activities.

The DPECSHN Director of Special Projects participates on the planning committee for the Youth Leadership Forum for high school juniors and seniors with disabilities. The 4th YLF was held in September 2004; cosponsors include the Governor's Commission on Employment of People with Disabilities, Harvard University, & Partners for Youth with Disabilities.

Transition training, primarily in Spanish, is offered four times per year to parents of children and youth with special health care needs in several pediatric practices in which DPH Care Coordinators are located.

The SSI and Public Benefits coordinator is active in the statewide SSI Disability Coalition and the state Disability Determination Services Advisory Committee. The Coalition's focus is information and resource materials on the Ticket to Work and Work Incentives Act.

The SSI and Public Benefits program includes information and referral resources and training for agencies serving transitional youth re: 'Ticket to Work' updates, Protection and Advocacy for Beneficiaries of Social Security and Benefits Planning agencies in MA (Project Impact and BenePlan). The new Community Resource line provides telephone/email TA to agencies serving youth in transition such as ARCs, school systems, DMR, DMH, and community-based human service agencies. Information provided includes disability & income criteria for SSI/ CommonHealth for transitioning youth.

The Family Initiatives Director and Family TIES training coordinator have developed and deliver workshops on health care transition for families.

Four SBHCs are participating in a Kellogg-sponsored initiative (that began in FY04) that has as one of its objectives "to empower students to become advocates for their own health care needs". The Mass. DOE "Comprehensive Health Education Curriculum Frameworks" will be implemented to encourage the attainment of health literacy and advocacy skills.

As part of efforts to prepare youth with special health needs for all aspects of adulthood, the Abstinence Education program assured distribution of materials addressing sexuality, exploitation, and abstinence to schools, programs, & institutions serving parents and youth with special health care needs.

c. Plan for the Coming Year

The M-TAB consumer advisory group will continue to discuss findings and recommendations of the Massachusetts Health and Disability Research Partnership (MHDRP). Depending on funding, the longitudinal study to identify variables that affect transition outcomes for youth will be implemented.

As part of a new federal grant, DPH will contract with New England SERVE and the Mass. Consortium for CSHCN to develop a curriculum and implement transition training for care coordinators/case managers and parent-professionals from a variety of agencies and

organizations statewide. Since these staff already work with youth and families, the Transition Training is intended to provide the staff with the tools they need to help YSHCN transition successfully to adulthood. This project stemmed from recommendations developed by the Mass. Consortium for CSHCN's Transition Task Force.

As part of the new federal grant, DPH will also develop a diverse Youth Advisory Council consisting of approximately 20 YSHCN to advise DPH and the MA Consortium for CSHCN on ongoing services and supports related to transition to the adult health care system, work and independence. This will be done via a contract with Partners for Youth with Disabilities, which will recruit members and provide training and support. Over the next year, YAC members will be recruited and 5 meetings will be held. Specific YAC activities will be determined by YAC members.

The Care Coordination program will develop systems for providing transition services to all CYSHCN over 16 years old. Care coordinators will receive training in transition to adult life for CYSHCN. These efforts are part of the new federal grant.

The Kellogg-sponsored initiative in school-based health centers will continue.

Distribution of brochures and materials previously developed by the Abstinence Education Program for youth and their families with special health needs will continue, in order to enhance the network of collaborators that provide services and referrals to youth with special health care needs.

The 5th Youth Leadership Forum for high school juniors and seniors with disabilities is being planned for Spring, 2006.

As part of the EOHHS Communities FIRST initiative, develop options to assist youth making the transition to living independently or in the community.

Explore options to expand Massachusetts Hospital School research models for the adaptation of living space.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	80	80	80	83
Annual Indicator	80.1	77.4	77.8	86.2	88.1
Numerator					
Denominator					
Is the Data Provisional or				Final	Final

Final?					
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88.1	88.1	88.2	88.2	88.2

Notes - 2002

Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MCV, 3 or more of Hib, and 3 or more of HepB). Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/nip/coverage/default.htm. All historic annual data have been revised to reflect NIP rates. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11. Data for 1996, 1997, and 1998 are reported on a calendar year basis (Quarters 1 - 4 of the referenced year); data for 1999 - 2002 are reported on a fiscal year basis (e.g. FY02 = Quarters 3 & 4 of 2001 and Quarters 1 & 2 of 2002).

Massachusetts had set our Annual Objectives through 2007 at the Healthy People 2010 goal of 80%.

Notes - 2003

Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MCV, 3 or more of Hib, and 3 or more of HepB). Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/nip/coverage/default.htm. All historic annual data have been revised to reflect NIP rates. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11. Data for 1996, 1997, and 1998 are reported on a calendar year basis (Quarters 1 - 4 of the referenced year); data for 1999 - 2003 are reported on a fiscal year basis (e.g. FY03 = Quarters 3 & 4 of 2002 and Quarters 1 & 2 of 2003).

Notes - 2004

Fully immunized corresponds to the CDC definition of 4:3:1:3:3 (4 or more doses of DTP, 3 or more of poliovirus, 1 or more of any MCV, 3 or more of Hib, and 3 or more of HepB). Data are from the National Immunization Survey, as reported by the CDC at http://www.cdc.gov/nip/coverage/default.htm. All historic annual data have been revised to reflect NIP rates. Because the percentage rates are generated by the NIP from surveys, no numerators and denominators are presented in Form 11. Data for 1996, 1997, and 1998 are reported on a calendar year basis (Quarters 1 - 4 of the referenced year); data for 1999 - 2004 are reported on a fiscal year basis (e.g. FY04 = Quarters 3 & 4 of 2003 and Quarters 1 & 2 of 2004).
Based on the improvement in this measure since 2002, Annual Performance Objectives through FY09 have been raised.

a. Last Year's Accomplishments

Among WIC enrolled children, 72.5% aged 24-29 months received their 4-3-1-3 series by 24 months of age and 77.1% children aged 12-17 received their 3-2-2 series by 12 months.

The Division of Primary Care and Health Access currently contracts with 32 pediatric primary care provider agencies (typically community health centers) that manage 43 program sites. During FY04, the Massachusetts Immunization Program (MIP) Nurses conducted Immunization Assessments at 33 of these sites with the MCH Immunization Program staff participating in 15 assessments.

In FY04 the criteria for the Immunization Assessments changed to a threshold level or passing score of 80%, as compared to 90% in FY03. Of the 33 combined primary care program

contracting sites that were assessed, 14 sites had a passing score of > 80%. Of the sites that failed, 6 sites had a threshold level between 70% and 80% with 2 sites failing by 1 chart.

During FY04, eleven (11) pediatric primary care sites contracted through the Combined Primary Care Program (CPCP) -- pediatric component, were targeted for intervention in order to improve their pediatric immunization practices. The MCH Immunization Program Coordinator and the Community Health Services Program manager jointly visited these sites. The results and recommendations included in the MIP Immunization Assessment were discussed at these visits and strategies were developed for improving rates.

MCH Immunization Program staff continue to work with the immunization staff of the Boston Immunization Program to better coordinate assessments and follow-up activities for the sixteen contracted CPCP-pediatric sites located in Boston.

Three (3) Immunization In-Services were provided for local program staff, including Early Intervention Partnerships Program and FIRSTLink. The in-services were conducted in three regions. Program staff and CHC staff from 26 agencies participated in the in-services with a total of 92 staff attending the three in-services. A total of 92 material packets including videos were distributed to the staff that attended the in-services. An additional 68 material packets were distributed for staff who were unable to attend, for a total of 160 packets.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 54 community health centers offer primary care to children regardless of insurance or ability to pay	X	X		
2. BFCH funds specialized outreach and care coordination in 31 pediatric primary care sites		X		
3. Immunization level is a contract performance measure for primary care and WIC sites				X
4. All programs that work directly with children assess for immunization status and primary care access		X		
5. All unimmunized children are referred by WIC staff as part of immunization assessment at enrollment		X		
6. Work with MA Immunization Program to ensure contracted providers have regularly updated information				X
7. EI Partnership Programs, FIRSTLink, Perinatal Connections, and FOR Families promote well-child care, including immunizations		X		X
8. EI programs provide information on immunization to all families and refer when indicated		X		X
9. Child care providers provide information on immunization to all families and refer when indicated				X
10.				

b. Current Activities

All BFCH programs that interact directly with families of infants and young children are charged with assessing health care access and the child's immunization status. Referrals and assistance with access to care are offered to families of children who are not fully immunized. Immunization assessment, education and referrals are provided at all certification and

recertification visits. Routine immunization assessment and referral by WIC staff is a contract performance measure, monitored during annual evaluation of program's performance. WIC provides training, monitoring and evaluation of program activities, and technical assistance to programs with rates below the state average.

The Bring a Book, Get a Book campaign, funded by the MIP, serves as an incentive for parents/caregivers to bring updated immunization records to their WIC appointment and receive a children's book.

MCH Immunization Program staff met routinely with program managers to coordinate the plan to address immunization practices at sites that have failed assessments. Any concerns over immunization issues were discussed at that time.

The MCH Immunization Specialist maintains an immunization information mailing list of BFCH contracted program sites. This list includes Early Intervention Partnerships Program (EIPP), Essential School Health Services, FIRSTLink, School Based Health Centers, Children with Special Health Care Needs and health education programs. Each of these BFCH contracted programs receives written information on immunization services.

All immunization-related information that the MCH Immunization Program staff receives from MIP via email is forwarded to the BFCH and to all Bureau staff working with programs serving families and/or children. The MCH immunization program staff continue to meet monthly with MIP and WIC staff to discuss and coordinate on immunization initiatives as well as program issues at the community level.

The MCH Immunization Program staff plans to work collaboratively with the Massachusetts Immunization Program in implementing the new Massachusetts Immunization Information System MIIS, which will soon be tested at pilot sites.

EI programs provide on-going information and resources to families on numerous well-child issues, including immunization schedules, during home visits and other aspects of service provision. Program-based service coordinators work with families to provide well-child information and resources and to incorporate this information into the IFSP as needed.

EIPP and FIRSTLink Home Visitors provide information and resources to families on numerous well child issues, including immunization schedules, during home visits and other aspects of service provision. EIPP works with families on an on-going basis to provide well child information and resources, and to assist in maintaining linkages with pediatricians.

FOR Families home visitors facilitate referrals and obtaining immunization records for homeless children.

c. Plan for the Coming Year

Current, on-going activities will continue from FY05.

Increased staff support funded by the Massachusetts Immunization Program will be provided for the MCH Immunization Program and CPCP-related initiatives.

Develop plans for the distribution and administration of combined and new vaccines, including plans for how to manage possible shortfalls.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	17.5	15.5	15.5	15	14
Annual Indicator	14.1	13.2	12.2	12.0	12
Numerator	1739	1627	1498	1473	
Denominator	123166	123166	123166	123166	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	12	12	12	12	12

Notes - 2002

Birth data are from MDPH, Vital Records for calendar years 1991 - 2001. This is the most recent year of data available. Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The 2001 denominator is the same as the 2000 denominator, as no 2001 population estimates are yet available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) produces the standard population estimates used by the Department of Public Health.

The 2000 denominator has been revised from the FY03 application. The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19. We are initiating conversations with MISER to determine if better annual estimates of the subgroup are possible.

Based on the improvements in this Measure since 1998, our Annual Objectives through 2007 have been adjusted to reflect lower baseline rates, but with very little further improvement. A number of changes in state funding are expected to reduce a number of programs and services addressing this problem.

Notes - 2003

Birth data are from MDPH, Vital Records for calendar years 1991 - 2003. This is the most recent year of data available. Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The denominators from 2001 forward are the same as the 2000 denominator, as no subsequent population estimates are available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) no longer produces the standard population estimates on a regular basis.

The number of female teens ages 15-17 is roughly estimated at 60% of the standard 5-year age group 15-19.

Based on the improvements in this Measure since 1998, our Annual Objectives through 2009 have been adjusted to reflect lower baseline rates, but with no further improvement. State funding cuts have reduced a number of programs and services addressing this problem; in addition, the overall rate is already quite low.

Notes - 2004

2004 birth data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

a. Last Year's Accomplishments

A science-based model of teen pregnancy prevention services delivery was adopted. Six community agencies successfully implemented evidence-based programs in the communities of Brockton, Chelsea, Holyoke, Lowell, Lynn and Springfield; each of these communities has teen birth rates that are at least double the state average. Programs being replicated include the Teen Outreach Program (TOP), a comprehensive service learning program; Making Proud Choices, an after-school, culturally-competent program model; and California's Adolescent Sibling Pregnancy Prevention Program, an intensive case management program targeting the siblings of parenting teens. Two remaining coalition-model programs and the six science-based ones delivered a total of 1,533 activities, with a focus on HIV/AIDS, STIs, human sexuality, and life skills.

The Abstinence Education Media Campaign produced two television, four radio health messages, and two posters for youth and their families; distributed abstinence-related educational materials and media products to approximately 1000 providers; participated in five-community outreach events for material distribution and to solicit community input for future material production; and coordinated distribution of materials and items targeting schools, community institutions, families, and faith-based organizations. [See NPM #6 for activities related to populations with special health needs.]

The Adolescent Health Report was completed and disseminated.

Family Planning vendor site assessments were conducted to ensure compliance with standards including specific standards on services to adolescents.

Family planning services were reduced by 41% in FY04 resulting in the closure of multiple sites, including one site in a high-risk community that serves 50% teens. Services were reduced significantly at other sites statewide. Fewer adolescents were served statewide.

The Family Planning Program continued ongoing quarterly Education Director's meetings to provide technical assistance and support to programs (despite funding elimination).

Core training for all EIPP Home Visitors included adolescent and family planning issues. The provision of family planning education and appropriate referrals is a core component of the EIPP services. Of all EIPP participants, 23% were teens under the age of 22 with at least 2 children.

Through collaboration with JSI Research and Training Institute, SBHC clinicians have been trained in "stage of change counseling," motivational interviewing, and various topics on adolescent sexuality.

Approximately 35% of SBHC visits of female clients ages 15-17 years involved screening for pregnancy risk. Risk reduction/prevention counseling was provided as appropriate.

The UMass / Simmons School Health Institute provided workshops for school nurses on: Adolescents and STIs; Working with Today's Adolescents (Anthony Wolf, PhD); and Creating a Collaborative Prenatal and Parenting Program.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Maintain an ACF-funded Abstinence Education program.			X	X
2. Teen Pregnancy Prevention coalitions in 2 communities with high teen birth rates		X		
3. Replicate science-based teen pregnancy programs in 8 communities with high teen birth rates (components include individualized case mgt, sex education, HIV/AIDS prevention, and service learning)		X		X
4. Comprehensive Family Planning clinical services, with specific standards for teens	X			
5. School-based Health Centers provide comprehensive primary care including reproductive health care	X			
6. Adolescent primary care sites offer specialized care including pregnancy prevention/family planning	X	X		
7. Most Essential School Health Services K-12 health education programs include reproductive health			X	
8. Home visiting programs screen for teen health risk behaviors and refer to family planning services		X		
9.				
10.				

b. Current Activities

As a result of modifications at the state level to the strategies allowed under the federally-funded Abstinence Education Program, a planning process is being initiated with the Mass. DOE to determine approaches to implementing classroom-only abstinence education in schools. Activities will be coordinated with other statewide adolescent health programs including school health, substance abuse, sexual assault, special health populations, and other abstinence education programs.

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The initial 6 science-based teen pregnancy prevention programs continue to deliver program curricula and services to youth. With an increase in state funding, two additional agencies were funded to replicate science-based interventions in the communities of Lawrence and New Bedford, for a total of 8 science-based programs and 2 coalitions in rural communities. The program models being replicated remained the same three as in FY04.

A statewide system of Family Planning (FP) agencies provides clinical services to adolescents. The FP program continues to work with Keep Teens Healthy, a Medicaid program providing family planning outreach to high-risk teens, and with the HIV/AIDS Bureau and John Snow, Inc (JSI) to offer training on behavioral risk assessment and sexual history taking in adolescents. Access coordinator and semi-annual statewide Abortion Advisory Committee meetings ensure all teens have access to services.

The Family Planning Program completed a comprehensive statewide needs assessment that incorporated a review of health indicators for adolescents as well as adolescent survey data. A Family planning RFR, released in January 2005 for services to be procured for FY06, prioritized service provision to adolescents, particularly in high-risk communities. Program standards, billing and service packages were revised to provide improved services to adolescents.

The Emergency Contraception Network has expanded to include more adolescent service providers and to provide more technical assistance and regional trainings on EC including to school-based health center clinicians.

Family planning services funding was restored to 92% of FY03 level, allowing for increased service provision to adolescents.

SBHC clinicians screen adolescents for reproductive health behaviors, STIs (including HIV) and pregnancy risk. Adolescents at risk are evaluated further to formulate a risk reduction plan. SBHC clinicians receive Health/Social Intervention Training. Special programs inform young women about healthy decision-making and delaying pregnancy. Increased collaboration with the Family Planning Program has facilitated enhanced technical assistance, including providing FP referral information for SBHC clinicians.

Short Interpregnancy interval (IPI) & short IPI by risk group (e.g. teens) data for 30 municipalities were included in the family planning needs assessment and RFR.

c. Plan for the Coming Year

Based on state funding availability, the Science-based Teen Pregnancy Prevention programs will continue, possibly at higher funding levels. Contingent on funding, an evaluation of the replications will be done.

Through continued collaboration with JSI Research and Training Institute, SBHC clinicians will receive training on "client-centered techniques" and clinical courses pertaining to adolescent health and sexuality. Ensure that this training addresses differences in adolescent development for Black and Latino youth.

New statewide family planning contracts will begin operation as of July 1, 2005.

Include IPI as an ongoing measure in the annual births release as well as develop program initiatives to decrease the percent of women giving birth who have short IPIs (<12 months).

As a follow-up to the short interpregnancy interval (IPI) data presented in the RFR, Family planning program staff will work with programs to implement strategies to decrease percent of short IPIs for their area.

BFCH staff will continue to monitor service delivery and provide technical assistance to ensure compliance with revised program standards, with specifics on serving adolescents.

Emergency contraception (EC) educational materials and information will continue to be distributed to adolescent service providers.

The re-focused federally-funded Abstinence Education Program will implement classroom-only abstinence education in schools. All activities will be coordinated with other statewide adolescent health programs including school health, substance abuse, sexual assault, special health populations, and other abstinence education programs.
.
Analysis of interpregnancy interval (IPI) data in the Pregnancy to Early Life Longitudinal (PELL) Database will continue, with continued attention to teens as a risk group.

Family planning staff will continue to meet with MassHealth to discuss strategies to decrease the percent of MassHealth women with short IPIs and development of a Medicaid family planning waiver.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22	50	50	60	60
Annual Indicator	21	58.3	59.7	58	62.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	62.2	62.5	65	65	65

Notes - 2002

The data for 2002 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A new children's dental health module, containing this and other questions, was introduced in the 2001 Survey and is now being carried out every year. Prior to 2001, our only data on the use of sealants have been based on school-based surveys in only a few communities. Such surveys, on larger samples of schools, will also be continued as possible in order to help validate the BRFSS findings. Because we are not yet confident that sealants are fully understood by all families and due to economic conditions, the projected future rates have been set conservatively. Because of the importance of oral health and the problems with using sealant utilization to track overall problems with access to preventive dental services in Massachusetts, we have included an additional oral health measure among our state negotiated measures (see SPM # 04).

Notes - 2003

The data for 2003 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A new children's dental health module, containing this and other questions, was introduced in the 2001 Survey and is now being carried out every year. Prior to 2001, our only data on the use of sealants have been based on school-based surveys in only a few communities. Such surveys, on larger samples of schools, will also be continued as possible in order to help validate the BRFSS findings. Because we are not yet confident that sealants are fully understood by all families and due to economic conditions, the projected future rates have been set conservatively.
The 2003 survey rate of 58.0% is slightly lower than the 2002 survey finding of 61% and slightly below our target rate of 60%. However, an actual rate of 60% is within the 95% confidence intervals for the survey (54.1% - 61.9%), and thus the data can be considered as showing an essentially flat rate at our target level. The survey rates within various socioeconomic

categories show consistently higher rates of sealants as parental education levels rise (33.1% with less than high school education compared with 65.7% with 4+ years of college) and as family income rises (35.2% at under $25,000 compared with 65.8% at over $50,000).
Because of the importance of oral health and the problems with using sealant utilization to track overall problems with access to preventive dental services in Massachusetts, we have included an additional oral health measure among our state negotiated measures (see SPM # 04).

Notes - 2004

The data for 2004 are taken from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). A new children's dental health module, containing this and other questions, was introduced in the 2001 Survey and is now being carried out every year. Prior to 2001, our only data on the use of sealants have been based on school-based surveys in only a few communities. Such surveys, on larger samples of schools, will also be continued as possible in order to help validate the BRFSS findings.
Despite the slight fluctuations in the survey reported rates between 58 and 62%, the data can be considered as showing an essentially flat rate. We have raised our target levels beginning in FY06. The survey rates within various socioeconomic categories show consistently higher rates of sealants as parental education levels rise (48.5% with less than high school education compared with 69.3% with 4+ years of college) and as family income rises (41.1% at under $25,000 compared with 68.4% at over $50,000). However, the gaps between income levels and education levels are decreasing.

a. Last Year's Accomplishments

The Office of Oral Health, in collaboration with Essential School Health Services Program and the Massachusetts Department of Education conducted a statewide oral health survey of third grade school children; 3,439 children were screened. The MDPH published the survey report, which documents that 54% of third grade school children have at least one dental sealant on a permanent molar.

CMSP's dental benefit included protective sealants for children. The CMSP reimbursement rate is similar to private industry contracted rates; this reduces access problems due to low reimbursement rates. Of children in CMSP ages 7-9, 23% received dental sealants. Since CMSP is often used between instances of private health insurance coverage, many of the enrolled CMSP children may have already had dental sealants.

School Health and the Office of Oral Health collaborated to implement sealant programs in the schools. 32 of the 103 ESHS school districts (31%) reported participating in a dental sealant program. 4,816 students had sealants applied in school.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CMSP dental benefits include protective sealants for children.	X			
2. Outreach and improved reimbursement rates for CMSP dental provider network				X
3. Leadership to improve oral health status with a focus on children and preventive services				X
4. On-going surveillance of 3rd grade children's oral health status, including sealants			X	X
5. A statewide dental sealant program in 21 communities serves over 3000 high-risk school children	X			

6. Strong collaboration between Office of Oral Health and school health programs, including SBHCs				X
7. Dental services provided in community health centers and other contracted primary care sites	X			
8. Specialist oral health consultant promotes preventive dentistry services for CSHCN		X		X
9.				
10.				

b. Current Activities

See also activities for SPM #4.

The 2003 survey data are being used by the Office of Oral Health to identify additional gaps in service. A plan to expand dental sealant programs to include high-risk communities where services currently are not available has been developed.

A statewide dental sealant program is currently operational in 31 communities serving over 4000 high-risk school children.

Expanded school-based and school-linked dental sealant programs in rural communities and high risk areas now reach children in New Bedford, North and South Worcester Counties, Central and Northern Berkshire County, Boston, Chelsea, Taunton, Holyoke, and Lowell. This year, a new dental sealant program entitled, Smart Smiles was formed in Boston. This collaborative effort between the Boston Public Schools, the Office of Oral Health and the dental institutions is targeting fourteen elementary schools this year. An estimated 2,500 children will receive dental sealants in Boston this year.

All contracted pediatric primary care sites provide screening and referral for oral health care, although one has reduced availability due to issues related to reimbursement and funding support for oral health care. Other providers also have fiscal concerns related to the service. BFCH staff continue to strategize and encourage implementation of oral health guidelines and to facilitate communication between contracting agency staff and appropriate oral health resources.

The new SBHC RFR funding cycle required among its performance measures an "increase in the percentage of students who receive preventive oral health care."

The ESHS programs require the development of a plan for oral health services which addresses 1) the assessment of oral health status as outlined by MDPH, 2) the provision of dental sealant programs either directly or through referrals, 3) implementation of school-based fluoride rinse programs in communities with non-fluoridated water, 4) review of vending machines, 5) school activities (events and fund-raisers) and food services with the goal of reducing sugar and starch intake, and 6) implementation of guidelines to ensure mouth-guard use in relevant contact sports. They also require that every child be assessed to determine whether he/she has a dental provider.

At the beginning of FY05, CMSP was transferred from DPH to the EOHHS, MassHealth Office of Acute and Ambulatory Care. Wellpoint Dental was retained until a contracting change necessitates that all CMSP children access dental services through MassHealth. Title V staff work with the Acute and Ambulatory Care program to continue to expand the CMSP network and develop a plan as required under FY05 state budget language to contract with a third party administrator for the state Medicaid oral health program.

c. Plan for the Coming Year

Current, on-going activities will continue from FY05.

Work with the Department of Youth Services to enhance the current services provided to all children and youth in state facilities. Explore expansion to other residential services.

Explore possible development of oral health services at the Massachusetts Hospital School for youth and young adults.

The revised Comprehensive School Health Manual will have an updated chapter devoted to oral health.

Essential School Health and School-Based Health Center programs will be reviewed to assure inclusion of all oral health components. TA will be provided to schools with inadequate plans or upon request.

Continue to explore needs/gaps for children with special health care needs and develop plans to address them.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.17	1.2	1.2	1.2	1.2
Annual Indicator	1.3	1.7	0.5	1.5	1.2
Numerator	16	21	6	19	
Denominator	1259376	1256376	1256376	1259376	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1.2	1.2	1.2	1.2

Notes - 2002

Data on deaths are taken from MDPH Vital Records for calendar years 1991 -2001. This is the most recent year of data available. Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The 2001 denominator is the same as the 2000 denominator, as no 2001 population estimates are yet available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/)

produces the standard population estimates used by the Department of Public Health.

Annual Objectives through 2005 have been adjusted to reflect a steady rate, rather than any decline.

Deaths in years 1999 and later are derived from ICD-10 codes (10th Revision of the International Classification of Diseases). Caution should be used in comparisons with previous years using ICD-9 codes.

Notes - 2003

Data on deaths are taken from MDPH Vital Records for calendar years 1991 - 2003. This is the most recent year of data available. Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The denominators from 2001 forward are the same as the 2000 denominator, as no subsequent population estimates are available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) no longer produces the standard population estimates on a regular basis.

Deaths in years 1999 and later are derived from ICD-10 codes (10th Revision of the International Classification of Diseases). Caution should be used in comparisons with previous years using ICD-9 codes.

Notes - 2004

2004 death data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

a. Last Year's Accomplishments

- The Injury Prevention and Control Unit (IPCP) coordinated with WIC staff, during National Child Passenger Safety (CPS) Week (in February) and National Buckle Up America Week (in May), to send out CPS materials to WIC participants. The two programs also developed WIC Minutes on CPS for these two events. The minutes ran through the week for each event.

The 2 CPS technicians in the IPCP each participated in 2 child safety seat checkpoints.
- The IPCP answered hundreds of calls on the Car-Safe toll-free line. Staff sent out materials as requested by the caller and referred caller to relevant partnering programs (WIC, School Health).
- IPCP held four Partnership for Passenger Safety Meetings.
- IPCP updated several materials, including the Car Seat Loan and Distribution Program list, the CPS Fact Sheet, and the Summer Safety Tips Sheets, with one focusing on passenger safety.
- IPCP staff helped plan the 4th Annual Moving Together Conference, in October 2002, which is the statewide bike/pedestrian conference, with two presentations involving pedestrian safety.
- IPCP Staff member attended the 2004 Johns Hopkins School of Public Health Summer Institute for Injury Prevention, held in July.
- WIC distributed educational materials on child passenger safety to program participants as well as information on how to contact the Child Passenger Safety Technician and Fitting Station in their community to ensure the proper installation of car seats.
- 1 staff member was certified as a Child Passenger Safety Technician in April through NHTSA's re-certification program.
- Participated in the planning of the MDPH World Health Day event, focusing on traffic safety, and planned booster seat raffle.
- National Child Passenger Safety Week and National Buckle Up America Week were promoted throughout the MDPH with lobby displays and letters to all staff from the Commissioner.

- Partnered with coalitions, such as the Greater Boston Safe Kids and Western Massachusetts Safe Kids Coalitions, Injury Free Coalition of Boston, the Injury Free Coalition of Worcester, and the SAFE Coalition to coordinate and plan passenger safety projects.
- Staff members wrote articles for the school health newsletter -- Updates in School Health -- on the topics of motor vehicle safety and pedestrian safety. The newsletter was distributed to 3800 superintendents, school nurses in all public and nonpublic schools, Boards of Health and others.

SBHC clinicians attended mandatory MDPH-sponsored meetings during which programmatic injury prevalence data were presented and analyzed. Epidemiologic trends were discussed including location of injury and primary causes (stratified by developmental stage). Guidelines for prevention were reviewed using "Bright Futures" materials.

EIPP Home Visitors provided information to parents on infant passenger safety and resources to obtain child safety seats with instructions for their proper use.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Child Fatality Review Teams operate in every county of the state				X
2. Participation in child safety seat checkpoints		X		
3. Dissemination of educational materials on child passenger safety to relevant MDPH programs, consumers, and providers			X	X
4. Active participation in safety/injury prevention coalitions and working/advisory groups				X
5. Develop 5-year strategic plan, with focus on traffic safety				X
6. Information/resources offered to pregnant women and parents of children in WIC		X		
7. Perinatal/pediatric primary care programs, EIPP, FOR Families, FIRSTLink, Perinatal Connections, ESHS, and SBHCs provide education to clients on passenger/ MV safety		X		
8. Facilitation of Partnership for Passenger Safety meetings				X
9. Maintain technical assistance capability by having at least one certified Child Passenger Safety Technician on staff				X
10. Work with Executive Office of Public Safety to develop joint strategies and initiatives			X	X

b. Current Activities

IPCP conducts or participates in many targeted activities related to motor vehicle safety, including:
- Maintain CPS Technician certification for at least 1 staff member (currently 1 CPS technician is on staff).
- Update and develop new materials, including the Massachusetts Child Passenger Safety Resource Directory and the Guide to Booster Seat Use.
- Coordinates with WIC staff, throughout the year, to send CPS materials to WIC participants.
- Continues to participate in child safety seat checkpoints.
- Continue to host The Car-Safe Line, which provides general passenger safety for Massachusetts residents. Staff sends out materials as requested by the caller.

- Facilitate Partnership for Passenger Safety meetings.
- Coordinate activities and educational outreach during Child Passenger Safety Week and Buckle Up America Week.
- Coordinate with School Health staff to send out CPS materials to school nurses and administrators.
- Coordinate with MassMoves staff to integrate traffic and pedestrian safety messages into physical activity promotion efforts.
- Continue to partner with coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, Injury Free Coalition for Kids of Worcester, and the SAFE Coalition.
- Help plan the Annual Moving Together Conference, that is the statewide bike/pedestrian conference, with one presentation focusing on motor-vehicle crashes involving bicyclists and pedestrians.
- One IPCP staff member attends the 2004 National Lifesavers (National highway safety conference).
- Develop 5-year strategic plan with focus on traffic safety.
- Collaborate CPS projects and materials with other state agencies, including Governors Highway Safety Bureau, MassRides.

EI Service Coordinators offer information to all families on their caseload on car seat safety for young children. EI Transportation Services maintains safety standards for all young children enrolled in EI who are transported to services and home. Transportation Services staff sponsor training in which EI program staff and transportation company staff have become certified child car seat technicians.

FIRSTLink, EIPP, and FOR Families home visitors provide information to parents on child/youth passenger safety and resources to obtain child safety seats with instruction for their proper use.

SBHC clinicians have received training on guidelines for prevention (e.g., Bright Futures), screening instruments available (GAPS, HEADS), clinical interviewing/risk assessment skills, and effective strategies for intervention. A required performance measure is "decrease in health injury risk factors among enrolled students."

Updated information on injury prevention is provided through the Friday e-mails to all Essential School Health Services programs.

Child Fatality Review Teams are operational in all counties. Designated BFCH staff participate actively.

c. Plan for the Coming Year

The IPCP plans a number of targeted activities:
- Maintain at least one certified CPS Technician on staff.
- Certify Staff member in Transporting Children with Special Health Needs.
- Coordinate four Partnership for Passenger Safety meetings.
- Host The Car-Safe Line and distribute passenger safety information to Massachusetts residents.
- Hold workshop at the MAPHERD Conference with a focus on Child Passenger Safety.
- Evaluate and respond to recommendations made in the Child Fatality Review Annual Report that concern issues of Child Passenger Safety and Bike/Pedestrian Safety.
- Help plan the 4th Annual Moving Together Conference, with at least one presentation on bicycle injuries related to motor-vehicle crashes.
- Update and develop new passenger safety related materials.
- Coordinate with WIC staff to distribute CPS materials to WIC participants.

- Coordinate with EI to participate in organization of CPS Technician Trainings and Special Needs Trainings. Distribute updated CPS materials to EI participants.
- Coordinate with other state agencies to develop plan for a statewide Safe Routes to School Program with an emphasis on traffic and pedestrian safety.
- Participate in three child safety seat checkpoints.
- Publish articles on passenger safety issues in "Issues in School Health" and other publications.
- Have at least one staff person attend the annual National Lifesavers Conference.
- Coordinate passenger safety activities with coalitions, such as the Greater Boston Safe Kids Coalition, Western Mass. Safe Kids Coalition, Injury Free Coalition for Kids of Boston, Injury Free Coalition for Kids of Worcester, and the Prevent Injuries Now Coalition.
- Improve collaboration and integration of CPS information and materials with additional state agencies serving children.
- Include CPS information in each quarterly mailing of seasonal and new injury prevention information/materials to over 400 providers, including educators, fire and police, advocates, health care provides, and MDPH programs.

Through the revision of the Maternal-Newborn Regulations for hospital licensure, recommendations have been developed to incorporate child safety information in patient education materials.

WIC staff will participate on the Advisory Committee for the development of the Injury Prevention and Control state plan.

Develop joint initiatives to promote driver and passenger safety with the Executive Office of Public Safety, building on the strengths of both agencies.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	72	73	74	75	75
Annual Indicator	71.3	74.0	74.7	76.6	76
Numerator	58188	59911	60266	61388	
Denominator	81582	81014	80624	80167	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	77	77	78	78	79

Notes - 2002

Breastfeeding at discharge and resident birth data are from MDPH, Vital Records for calendar years 1991 - 2001. This is the most recent year of data available.
The percentages on Form 11 differ from those published elsewhere due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births. In MassCHIP and most Massachusetts publications, percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage. The differences are generally small but were pronounced for 1996, when the impact of implementation of major revision to the birth certificate form and transmission system resulted in a significantly higher rate of unknown values for some variables, including breastfeeding. Projections were based on the assumption that the true rate did not dip in 1996. This assumption is borne out by subsequent data, as the rate has returned to its upward trend. Slight adjustments have been made in the Annual Objectives through 2007.

Notes - 2003

Breastfeeding at discharge and resident birth data are from MDPH, Vital Records for calendar years 1991 - 2003. This is the most recent data available.
The percentages on Form 11 differ from those published elsewhere due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births. In MassCHIP and most Massachusetts publications, percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage.

Although progress has been slow on this measure, we are raising our target levels beginning in FY06, as increased efforts are being made to improve the outcomes.

Notes - 2004

2004 birth data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

Although progress has been slow on this measure, we are raising our target levels beginning in FY06, as increased efforts are being made to improve the outcomes.

a. Last Year's Accomplishments

Statewide 69.1% of WIC enrolled mothers initiated breastfeeding for infants born in FY04, with 6 local programs above 80%, and 7 above 75%. As of June 2003, there were 8,539 breastfeeding women in WIC programs, which represents 31% of all infants on WIC.

20 WIC Programs with more than 60 peer counselors -- many having multiple years of service -- were funded for the 'Mother to Mother' Breastfeeding Peer Counselor Program.

In collaboration with the MA Breastfeeding Coalition (MBC), Nutrition Division staff translated and distributed more than 75,000 breastfeeding brochures "You've Got What It Takes..Give Your Baby the Best" for prenatal women to over 35 hospitals, birth centers and childbirth education programs.

314 EIPP participants received an initial comprehensive health assessment, 67% were found to have low or moderate levels of strength in the area of breastfeeding. While 63% of all EIPP participants were breastfeeding at birth, only 8% continued to breastfeed at six months postpartum. Barriers for mothers continuing to breastfeed include domestic violence, depression, easy access to infant formula, lack of support at place of employment, and mothers choosing to utilize illegal substances.

The "Perinatal Primary Care Program/Massachusetts Pregnancy Nutrition Surveillance 2003 Statewide Summary Data Report" indicates 76% of infants were ever breastfed. A small

increase from the 2002 report, and compares with the Massachusetts statewide data of 75.0% of all infants ever breastfed at hospital discharge as per data reported for 2002, national data that indicates 55.7% of infants born to women in the 2002 PNSS were ever breastfeed (CDC, 2003).

CPCP and WIC program staff coordinated an intensive update and review for all CPCP and WIC program contracts. Agencies reviewed and revised their local program coordination agreements for comprehensive, unduplicated and timely services for combined primary care and WIC and revised mutual agreements for high-risk protocols, referral and tracking procedures that ensure timely entry into primary care services and the WIC program, and coordination for other high-risk referrals.

The State Breastfeeding Coordinator activities included:
* A complete revision of the Breastfeeding Resource Guide-2004 Edition. (> 8,000 copies have been distributed free of charge since the Resource Guide was first developed in 1998.)
* Sponsored the gubernatorial proclamation for Mass. Breastfeeding Week-Aug.1-7, 2004, signed by Gov. Mitt Romney.
* Sponsored a 'Breastfeeding-Friendly Business Award' and 'Breastfeeding-Friendly Employer Award' campaign during World Breastfeeding Week.
* Planned the 3d annual "Breastfeeding in the Bay State" Conference for health care providers.

The NPAU (MOPCI Program) funded the printing of Breastfeeding Works: Breastfed Babies in Childcare as part of the MOCPI state plan. CDC has requested that OCPI funded states include breastfeeding within their state activities as a way to help prevent obesity.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Multi-faceted approach to reach health care professionals, parents/extended family, and general public		X	X	X
2. Breastfeeding Coordinator provides active leadership to promote breastfeeding statewide				X
3. Make Guidelines for Promoting and Supporting Breastfeeding available to all hospital maternity units and EIPP home visiting nurses				X
4. Nutrition Division routinely produces and disseminates educational materials to promote breastfeeding in WIC and primary care programs		X	X	X
5. Educational materials given to pregnant women through EIPP and perinatal primary care		X		
6. WIC counsels all women on benefits of breastfeeding and actively encourages breastfeeding; offers peer counseling services and provides manual breast pumps		X		
7. Actively collaborate with the Mass. Breastfeeding Coalition				X
8. Regular trainings for primary care and WIC professional and paraprofessional providers				X
9. Perinatal home visiting program supports lactation consultants and intensive breastfeeding support		X		
10. Revise Perinatal Regulations to increase support for breastfeeding in hospitals.				X

b. Current Activities

The State Breastfeeding Coordinator participates in planning the annual "Breastfeeding in the Bay State" conference, in the development of tools for health care providers to assess and promote breastfeeding in the hospital and primary care settings. She works with MassHealth staff to address issues of breast pump coverage for mothers/infants separated for medical reasons. The coordinator participates in the MA Breastfeeding Coalition.

Prenatal infant feeding groups emphasize benefits, initiation and management of breastfeeding. Postpartum breastfeeding women in WIC receive additional breastfeeding education and support. Local WIC programs establish goals for breastfeeding initiation rates of women enrolled prenatally.

WIC offers biannual "Breastfeeding Basics" training and annual "Beyond Breastfeeding Basics" training to WIC nutrition staff and other interested staff of related programs.

WIC and CPCP staff collaborate and coordinate care for pregnant and breastfeeding women. Local WIC/Primary Care agreements are reviewed to ensure breastfeeding education and support are provided to all prenatal and breastfeeding women. Introduction of breastfeeding at the first prenatal visit is a performance measure for CPCP programs. Prenatal nutrition visits include infant feeding, maternal nutritional health and the importance of breastfeeding with instruction starting after the 32nd week of pregnancy.

WIC, the Nutrition and Physical Activity Unit and MaxCare printed "Breastfeeding Works! Breastfed Babies in Child Care," a resource for child care providers and can be found on the OCC website. WIC conducted meetings with the OCC to plan regional trainings for childcare providers to support BF in the workplace. This is now incorporated within OCC mandated trainings for health care providers.

EIPP has a particular emphasis on improving breastfeeding initiation and duration rates including both prenatal and postpartum education, assessment and support utilizing the MCH Nurse and lactation consultant services.

In collaboration with 18 perinatal advocacy/support organizations, MDPH implements the annual "Partners in Perinatal Health Conference," providing training and multidisciplinary networking opportunities for an audience of 450 providers. Workshops focus on breastfeeding and participants received materials about the WHO Breastfeeding Code.

Breastfeeding support is provided in the home by all FIRSTLink home visitors.

Revisions to the Massachusetts Perinatal Regulations will strengthen support for early initiation of breastfeeding in birth hospitals, including requirements for lactation care and services, promotion of breastfeeding practices, linking women with community resources on discharge and limits on the open display of formula company marketing materials.

WIC is participating in the USDA "Loving Support for Breastfeeding Peer Counseling" project, focused on improving and enhancing the management component of the current breastfeeding peer counseling program.

c. Plan for the Coming Year

The revised Massachusetts Perinatal Regulations will be promulgated, with the strengthened requirements for support of breastfeeding by birth hospitals.

WIC and Primary Care will collaborate with the EIPP to ensure participants have access to breastfeeding promotion, education and support prenatally and throughout the breastfeeding experience. (See Attachment to NPM # 17 for more information on the new Regulations.)

WIC, MaxCare and the Office of Child Care Services will collaborate to provide regional trainings to child care providers statewide using the "Breastfeeding Works!" brochure and corresponding training. Possible funding of the brochure by MOCPI for non-WIC populations (e.g. OB and child birth providers) will be investigated.

The EI Partnership Programs (EIPP) will continue their emphasis on improving breastfeeding initiation and duration rates.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	98	99	99	99
Annual Indicator	98.5	99.6	99.9	99.9	100.0
Numerator	80358	81319	79294	81444	79399
Denominator	81582	81638	79373	81545	79400
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99.9	99.9	99.9	99.9	99.9

Notes - 2002

Pre-discharge screening rates are estimated from data received from MDPH annual surveys of all Massachusetts birth hospitals. As of November l998, Massachusetts law mandated that all newborns in Massachusetts must have their hearing screened prior to discharge from a birth hospital. Amendments to Hospital Licensure and Birth Center Regulations regarding Universal Newborn Hearing Screening Programs became effective on September 1, l999. Eventually, actual screening (and follow-up) data will be available from the birth certificate and a new newborn hearing data system, with linkages to FIRSTLink and Early Intervention, will be implemented. These changes will result in improved data and outcome tracking.
Projected targets assume exclusion from the denominator of any parents refusing the screening; this number has been extremely small to date. The speed with which hospitals have implemented the law exceeded our expectations when our targets were originally set.

Notes - 2003

Pre-discharge screening rates are estimated from data received from MDPH annual surveys of all Massachusetts birth hospitals. As of November l998, Massachusetts law mandated that all newborns in Massachusetts must have their hearing screened prior to discharge from a birth hospital. Amendments to Hospital Licensure and Birth Center Regulations regarding Universal Newborn Hearing Screening Programs became effective on September 1, l999. Eventually,

actual screening (and follow-up) data will be available from the birth certificate and a new newborn hearing data system, with linkages to FIRSTLink and Early Intervention, will be implemented. These changes will result in improved data and outcome tracking.
Projected targets assume exclusion from the denominator of any parents refusing the screening; this number has been extremely small to date. The speed with which hospitals have implemented the law exceeded our expectations when our targets were originally set.

Notes - 2004

As of November l998, Massachusetts law mandated that all newborns in Massachusetts must have their hearing screened prior to discharge from a birth hospital. Amendments to Hospital Licensure and Birth Center Regulations regarding Universal Newborn Hearing Screening Programs became effective on September 1, l999.
Prior to 2004, pre-discharge screening rates were estimated from data received from MDPH annual surveys of all Massachusetts birth hospitals. Effective with 2004, actual screening (and follow-up) data are available from the electronic birth certificate (EBC). A new newborn hearing data system, with linkages to FIRSTLink and Early Intervention, is also being implemented. We are still monitoring hospital survey reporting and comparing the survey and birth certificate results to assure data quality.
Based on our understanding of MCHB definitions for this measure, the numerator and denominator capture in-state resident births. I.e. they exclude out-of-state resident births and occurrence births to residents of other states. The method also excludes all screens done after discharge, regardless of how soon. This differs from CDC reporting protocols and therefore the data may differ from other published findings. The method also may leave “border babies” potentially uncounted in any state, an issue that the New England states are exploring in a broader context. We would welcome clearer joint instructions and data definitions from MCHB and CDC.
The use of the early EBC data (i.e. we are reporting newborn hearing screening data for 2004, while all other birth data are only officially available – and reported – for 2003) also makes the data preliminary. The denominator is higher than the preliminary estimate provided by MDPH and used in Form 6, for example. Removal of duplicate records continues and final 2004 birth data will not be available until winter, 2006. The UNHSP preliminary EBC numerator and denominator are reported here and will be updated at a later date.

Projected targets of less than 100% assume exclusion from the denominator of any parents refusing the screening; this number has been extremely small to date.

a. Last Year's Accomplishments

More than 99% of newborns received hearing screening prior to discharge from a birthing facility. Outreach was conducted to families with newborns that did not pass their hearing screening. Training was provided to DPH approved audiological assessment/diagnostic centers on: Hearing and Amplification, Hearing Aid Choices and Recommendations for Infants and Toddlers, Guidelines for Collecting and Reporting of Audiological Evaluation Results, Genetics and Public Health, and the Genetics of Hearing Loss.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All newborns receive hearing screening prior to birth facility discharge			X	
2. The Universal Newborn Hearing Screening Program (UNHSP) reviews and approves all hospital protocols				X
3. UNHSP staff conduct site visits to all hospitals and provide technical assistance as needed				X

4. Outreach staff track families to ensure that all children receive appropriate follow-up care		X		
5. UNHSP follow-up assures referrals to EI for infants who do not pass the screening		X		
6. Additional linkages, including Care Coordination for CSHCN and primary care, are made as needed		X		
7. Public information materials, including parent information kits, are distributed			X	X
8. Parent to parent support is offered to all families of children identified with hearing loss		X		
9. Perinatal Hospital Licensure Regulations are revised related to newborn hearing screening				X
10. Program evaluation activities are performed, including family and primary care surveys and analysis				X

b. Current Activities

The newborn hearing screening law and hospital licensure regulations require screening of all newborns. All birthing facilities have approved protocols for hearing screening, and results are tracked for the approximately 82,000 infants born in MA each year through the electronic birth certificate (EBC). Universal Newborn Hearing Screening Program (UNHSP) staff perform site visits at all birthing facilities, and provide TA as needed. The EBC and Childhood Hearing Data System provide outreach staff with the ability to systematically track families to ensure that all children identified through newborn hearing screening receive appropriate services, including EI.

Over 100,00 newborn hearing screening program brochures were distributed in five different languages. Parent Information Kits were updated and over 700 Kits were distributed to families with young children with hearing loss and others.

The UNHSP has approved protocols for 26 audiological assessment/diagnostic centers throughout the state. Designated representatives from each center meet three times per year and ongoing training is provided. Training was provided on the Centers for Disease Control and Prevention, National Early Hearing Detection and Intervention (EHDI) initiative and Medical Management of Hearing Loss.

The Newborn Hearing Screening Program disseminated parent surveys to approximately 3,250 families to assess satisfaction with newborn hearing screening and intervention. In addition, a survey was developed in collaboration with Jane Stewart, M.D., Early Hearing Detection and Intervention Representative, Massachusetts American Academy of Pediatrics to assess primary care clinicians understanding of newborn hearing screening and intervention. Two hundred surveys were disseminated.

Existing hospital licensure regulations and program standards have been reviewed to assure that needed changes are included in the revised Perinatal Hospital Licensure Regulations now ready for promulgation.

c. Plan for the Coming Year

Current, on-going activities will continue from FY05, including further development of data systems.

Develop a plan to decrease the number of children lost to follow-up.

Staff from the UNHSP and ASETS plan to analyze and report on survey results from the Family Satisfaction and Primary Care Clinician surveys.

The revised Perinatal Hospital Licensure Regulations will be promulgated and the newborn hearing screening requirements (that reinforce the state statute) will be supported.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3	3	2.5	3.5	3.5
Annual Indicator	2.5	1.9	2.5	2.3	3.2
Numerator	34066				
Denominator	1389583				
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	3	2.5	2.5	2.5	2.5

Notes - 2002

The data sources for this indicator vary from year to year; all are estimates. Previous sources have included Current Population Survey (CPS), health insurance status surveys of Massachusetts residents conducted by the Massachusetts Division of Health Care Finance and Policy (HCFP) biannually, and the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), which now includes questions on insurance coverage for household members under the age of 18. The FY01 estimate was derived only from the BRFSS. The estimated rate of 2.45% for FY02 is a average of the rate reported by the 2002 HCFP survey (3.2%) that reported by the 2002 BRFSS (1.7%). Performance Objectives through 2007 have been adjusted to remain at 2.5%, as further progress is not foreseen in the near future. In fact, the rate may be higher when the FY03 and FY04 data are reported.

Notes - 2003

The data sources for this indicator vary from year to year; all are estimates. Previous sources have included Current Population Survey (CPS), health insurance status surveys of Massachusetts residents conducted by the Massachusetts Division of Health Care Finance and Policy (HCFP) biannually, and the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), which now includes questions on insurance coverage for household members under the age of 18. The FY01 estimate was derived only from the BRFSS. The estimated rate of 2.45% for FY02 is a average of the rate reported by the 2002 HCFP survey (3.2%) that reported by the 2002 BRFSS (1.7%). The FY03 estimate of 2.3% was again derived only from the BRFSS, as no HCFP survey was carried out. [In FY04, there will again be data from both

surveys.]. The 95% confidence intervals for the 2.3% 2003 estimate are 1.3% - 3.2%. Hispanic families, families with less than a high school education and those with income under $25,000 reported the highest uninsured rates (7.7%, 7.2%, and 6.1% respectively).
As the BRFSS survey has consistently generated estimated rates that are lower than those found in the HCFP surveys, the rise in the BRFSS estimated rate of uninsured children (up to 2.3% from 1.7%) suggests that the changes in the state's economy and the limitations on CMSP enrollment in FY03 did adversely affect children's access to insurance. The 2004 HCFP survey will give us an even better estimate of the true changes and their impact by such variables as family income, race/ethnicity, and employment status.

Notes - 2004

The data sources for this indicator vary from year to year; all are estimates. Previous sources have included Current Population Survey (CPS), health insurance status surveys of Massachusetts residents conducted by the Massachusetts Division of Health Care Finance and Policy (HCFP) biannually, and the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS), which now includes questions on insurance coverage for household members under the age of 18. The FY01 estimate was derived only from the BRFSS. The estimated rate of 2.45% for FY02 is an average of the rate reported by the 2002 HCFP survey (3.2%) and that reported by the 2002 BRFSS (1.7%). The FY03 estimate of 2.3% was again derived only from the BRFSS, as no HCFP survey was carried out. The 95% confidence intervals for the 2.3% 2003 estimate are 1.3% - 3.2%. Hispanic families, families with less than a high school education and those with income under $25,000 reported the highest uninsured rates (7.7%, 7.2%, and 6.1% respectively).
The estimated rate of 3.2% for FY04 is the rate reported by the 2004 HCFP survey. By comparison, the 2004 BRFSS survey reported a rate of 2.6%.
As the BRFSS survey has consistently generated estimated rates that are lower than those found in the HCFP surveys, the rise in the BRFSS estimated rate of uninsured children (up to 2.6% from 2.3% in 2003 and 1.7% in 2002) suggests that the changes in the state's economy, public and private insurance systems, and other factors may be affecting access to health insurance for some families. The 2004 HCFP survey rate, on the other hand, although higher is unchanged from its 2002 estimate.
As a result of a number of emerging state initiatives, we are hopeful that the rate will fall and our current targets (which are already lower for 2006 and beyond) can be reduced even further.

a. Last Year's Accomplishments

Massachusetts was granted an expansion of the SCHIP guidelines to include all "unborn children" born to non-qualified MassHealth mothers. This ensures that all Healthy Start mothers of these "unborn children" can receive comprehensive medical coverage throughout their pregnancy and that the state can receive federal matching of 65% for all services spent on this population.

MassHealth and CMSP use a single application to ensure that children are enrolled or referred to the appropriate programs, which also provides seamless coverage for the unborn child, who will remain enrolled in SCHIP after birth.

83% of all EIPP Participants were on MassHealth while an additional 7% were receiving Healthy Start health benefits and an additional 7% were uninsured. Of the 314 EIPP Participants who received an initial comprehensive health assessment, 68% were found to have a low or moderate level of strength in the area of access and utilization of care, including health insurance, indicating a risk that prompted further examination and the provision of health education and guidance. EIPP Home Visitors provided screening and information to all EIPP Participants, making 42 referrals for health insurance

It is a priority of the SBHC program to screen all children and families for health care access and coverage. The new funding cycle RFR encouraged and assisted SBHC vendors to attend "Reimbursement and Managed Care in SBHCs" training. This included an update on the

Medicaid Program and a discussion of strategies to ensure that SBHC-enrolled students have health care access and coverage.

The Essential School Health Services (ESHS) programs are required to assess all children for health insurance status. In FY04, 9,340 children were referred for health insurance.

The Massachusetts Community Health Worker Network Project specifically seeks venues for promoting MCH services in underserved populations, through culturally and linguistically competent outreach and collaboration building. The Network implemented trainings and networking activities designed specifically to teach community health workers (CHWs) strategies for increasing prenatal care utilization in culturally and geographically diverse target populations, as well as advocacy skills for MCH CHWs.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All BFCH programs screen for health insurance status, and refer and assist with enrollment as needed		X		
2. Training and TA for community health workers on addressing barriers to health care access				X
3. Work with Medicaid/SCHIP on revised joint efforts to encourage and promote enrollment				X
4. Work with providers to maintain awareness of programs and to facilitate enrollment				X
5. Work with community and advocacy groups to maintain awareness of programs and to facilitate enrollment				X
6. Training and TA offered to providers and parents on SSI and public benefits that provide health insurance for CSHCN		X		X
7. See also activities for NPM #4, re CSHCN				
8. FOR Families, EIPP, FIRSTLink and Perinatal Connections home visitors provide information to families on SSI and public benefits and assist with enrollment in health insurance		X		
9.				
10.				

b. Current Activities

A priority for all BFCH programs with direct family contact is to screen for health care access and insurance coverage, make referrals, and provide assistance to access coverage and care appropriate to the program and family. See also activities in NPM 2 and NPM 4.

Teen Pregnancy Prevention programs provide information and referrals, including print materials, on access to health care and services available to youth and families.

The Community Health Worker Network Project provides technical assistance, training, and support to community health workers (CHWs) in Massachusetts. In addition, the project develops core competencies and best practices for MCH outreach. The project continues to build on a three-year award from the MCHB CISS/COG program (2000-2003), and continues to

expand the existing statewide community health worker (CHW) system. The project increases the capacity of CHWs to address barriers to increased access to and utilization of preventive health care and other MCH services. Through consistent and comprehensive training and networking opportunities, CHWs increase public awareness and knowledge of DPH services and resources for the MCH population. All training and networking sessions include presentations, strategies and materials relevant to enrollment in state insurance programs for children and to health promotion and preventive care.

Also building on the MCHB CISS/COG, as well as the PCO grant, in FY05 the Massachusetts Community Health Worker Report ("Community Health Workers: Essential to Improving Health in Massachusetts") was released and is being distributed widely throughout the state to CHWs, CHW employers and other community-based agencies and health care organizations, as well as to MCH advocates and policy makers.

The EIPP MCH Nurse conducts comprehensive health assessments of pregnant and post partum women and their infants at key developmental stages. All children are screened for health insurance status and referral and assistance with enrollment is provided as needed for any child without health insurance.

Training and TA on public benefits including SSI, CommonHealth, MassHealth and Kaileigh Mulligan continue as a major focus through the Community Support Program and may increase the number of eligible children receiving public health insurance. (see also NPM #2 and #4.)

The Essential School Health Services (ESHS) programs are required to assess all children for health insurance status.

c. Plan for the Coming Year

Current, on-going activities will continue from FY05.

Continue to provide ongoing technical assistance to SBHC vendors on developing collaborative relationships with Managed Care Organizations with the goal of increasing their capacity to bill for services.

Participate in state health care reform planning, including the restructuring of MassHealth (Medicaid) and development of the Safety Net Program as required by the renewed Medicaid 1115 waiver.

Assure that all existing and new programs continue to focus on enrolling all uninsured children in appropriate insurance plans.

Continue the integration of the ESM/EIM project (formerly known as STEPS at MDPH) into the Commonwealth's Virtual Gateway and add more programs to the ESM/EIM system, in order to assure that all potentially eligible children are enrolled promptly in Medicaid, CMSP, or other programs.

See also NPM #2 and NPM #4.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	82	90	90	90	93
Annual Indicator	91.3	95.3	93.8	93.6	94.3
Numerator	478742	401603	419948	404918	407918
Denominator	524151	421589	447508	432478	432478
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	94	96	97	97	97

Notes - 2002

Service data are provided by the Division of Medical Assistance, Information Analysis Unit. The numerator is the number of children aged 0 - 18 who received a service paid by MassHealth (Medicaid) during the state fiscal year. All children enrolled are assumed to have had at least one service paid for by the program. The denominator is made up of two components. The first is the total number of children aged 0 - 18 enrolled in MassHealth during the same period (provided by DMA). The second is an estimate of children not enrolled in Medicaid who might be eligible for it. For FY01, the denominator was the sum of 401,603 children enrolled in MassHealth and an estimate of 19,986 children unenrolled eligibles under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (40.3% of the 3% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2000 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).] (These data were not available at the time our FY01 Annual Report was filed and have been added now.)

For FY02, the denominator is the sum of 419,948 children enrolled in MassHealth and an estimate of 27,560 children unenrolled eligibles under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (52.1% of the 3.2% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2000 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]

There is a slight discrepancy in the age groups used for the estimates; it is not believed to affect the measure significantly.

Objectives through 2007 have been adjusted downward to 90%, based on the slight decrease from FY01 to FY02 and the ongoing uncertainties about both public and private insurance coverage and outreach.

(See Endnote to PM #13 also.)

Notes - 2003

Service data are provided by the Division of Medical Assistance. The numerator is the number of children aged 0 - 18 who received a service paid by MassHealth (Medicaid) during the state fiscal year. All children enrolled are assumed to have had at least one service paid for by the program. The denominator is made up of two components. The first is the total number of children aged 0 - 18 enrolled in MassHealth during the same period. The second is an estimate of children not enrolled in Medicaid who might be eligible for it.

For FY01, the denominator was the sum of 401,603 children enrolled in MassHealth and an estimate of 19,986 children unenrolled eligibles under age 19. [This estimate is calculated by

applying the estimated % of all uninsured children under 201% of the FPL (40.3% of the 3% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2000 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
For FY02, the denominator is the sum of 419,948 children enrolled in MassHealth and an estimate of 27,560 children unenrolled eligibles under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (52.1% of the 3.2% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2002 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
For FY03, the denominator is the sum of 404,918 children enrolled in MassHealth and an estimate of 27,560 children unenrolled eligibles under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (52.1% of the 3.2% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2002 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
The Medicaid source documents can be found on their website. (http://www.mass.gov/Eeohhs2/docs/masshealth/research/schip-2003_ar.pdf and http://www.mass.gov/Eeohhs2/docs/masshealth/research/1115_2003-demoar.pdf.) There is a slight discrepancy in the age groups used for the estimates; it is not believed to affect the measure significantly.
Objectives through 2008 have been adjusted upward slightly to 93%. (See Endnote to PM #13 also.)

Notes - 2004

Service data are provided by the Division of Medical Assistance. The numerator is the number of children aged 0 - 18 who received a service paid by MassHealth (Medicaid) during the state fiscal year. All children enrolled are assumed to have had at least one service paid for by the program. The denominator is made up of two components. The first is the total number of children aged 0 - 18 enrolled in MassHealth during the same period. The second is an estimate of children not enrolled in Medicaid who might be eligible for it.
For FY01, the denominator was the sum of 401,603 children enrolled in MassHealth and an estimate of 19,986 unenrolled eligible children under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (40.3% of the 3% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2000 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
For FY02, the denominator is the sum of 419,948 children enrolled in MassHealth and an estimate of 27,560 unenrolled eligible children under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (52.1% of the 3.2% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2002 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
For FY03, the denominator is the sum of 404,918 children enrolled in MassHealth and an estimate of 27,560 unenrolled eligible children under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (52.1% of the 3.2% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2002 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
For FY04, the denominator is the sum of 407,918 children enrolled in MassHealth and an estimate of 27,560 unenrolled eligible children under age 19. [This estimate is calculated by applying the estimated % of all uninsured children under 201% of the FPL (52.1% of the 3.2% uninsured) from the Massachusetts Division of Health Care Finance and Policy 2004 survey to the estimated population ages 0-19 from MassCHIP/MISER (1,653,092).]
The Medicaid and HCFP source documents can be found on their respective websites. (http://www.mass.gov/Eeohhs2/docs/masshealth/research/1115_2004-demoar.pdf; and http://mass.gov/Eeohhs2/docs/dhcfp/pdf/ins_status_04_report.pdf). There is a slight discrepancy in the age groups used for the estimates; it is not believed to affect the measure significantly.
Objectives through 2009 have been adjusted upward slightly to 94%. (See Endnote to PM #13 also.)

a. Last Year's Accomplishments

EIPP and FOR Families home visitors assisted families in enrolling in and renewing their MassHealth membership as needed, and assessed if MassHealth eligible children were actually receiving needed health care services. They promoted the importance of preventive health care and actively assisted families to address barriers to utilization of care, such as transportation, language, child care, etc.

The BFCH implemented a Well Child Chart Audit at contracting Combined Primary Care Program sites, starting in FY03 and ending in FY04. The Well Child Chart Audit looked at 22 EPSDT (Early Periodic Screening, Diagnosis and Treatment) performance measures for four age groups. A minimum of 10 charts or 10% (maximum of 20 charts) were audited for each of the four age categories, 1yr, 3yr, 10yr, and 15yr. At these site visits, those charts that did not have documentation of the 22 performance measures were identified and recommendations for improvement were discussed with staff at that time.

Some common strengths noted include organized charts, good follow-up for missed appointments, dental assessment, Lead screening for 1yr, appropriate referrals and Immunization history.

Common weaknesses included missing Family Medical History, blank Medication and Problem Sheets, no WIC Referral or Coordination documentation, missing Nutrition Assessments for 10yr and 15yr, Vision and Hearing for 3yr was only gross screening, and no documentation of TB Risk Assessment.

The audit establishes a baseline for performance measurement at the contracted community health centers and the assessment of strengths and weaknesses can be used for effective quality improvement initiatives and future request for response activities. Recommendations from the Well Child Chart Audit results when analyzed will be shared with each site, along with strategies for improvement.

In FY04, CMS approved MassHealth's SCHIP inclusion of "unborn children" for Healthy Start. The MBR also became the single application for HSP, thereby ensuring that the "unborn child" has coverage as well as continued seamless MassHealth coverage after birth.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. 54 community health centers provide pediatric care and accept MassHealth	X	X		
2. BFCH funds care coordination, and services not covred by insurance in 31 pedi and 18 adol primary care sites	X	X		
3. EI services and some EIPP services are reimbursed by MassHealth; families are assisted with barriers to care		X		
4. School-based health centers provide care to children and youth in elementary, middle, and high schools; some visits reimbursed by MassHealth; enrollment assistance offered	X	X		
5. Work with MassHealth to develop a waiver for Family Planning to expand services and income eligibility				X
6. FIRSTLink assists families of high-risk newborns to enroll in				

MassHealth and access care		X		
7. FOR Families conducts outreach and addresses barriers to care to ensure MassHealth eligible children receive needed services		X		
8. School nurses, as well as other health professionals in the schools, provide indirect care for children on MassHealth and promote enrollment for eligibles		X		
9. See NPM 3 and 4 related to CSHCN, and NPM 13 related to insurance for children				
10.				

b. Current Activities

Outreach and care coordination activities in contracted CPCP sites address barriers to utilization and ensure that children get needed care. Sites must have cultural and language diversity and are required to follow the Medicaid EPSDT and/or Bright Futures periodicity schedule for well child care. The rate of EPSDT services provided at contracting agencies is a performance measure.

Helping families and physicians optimize, upgrade, and fully utilize Medicaid coverage is a central focus of CSHCN Care Coordinators' activities. All 13 pediatric primary care practices in which Care Coordinators are located now have access to a set of standard templates to dramatically reduce time spent by physicians on recurring documentation tasks for prior Medicaid approval and develop new templates as Medicaid approval guidelines change.

FOR Families staff follow up with homeless families to ensure that MassHealth eligible children actually received needed services.

EI assists families of enrolled children with barriers to access to care, and refers to Medicaid at enrollment if uninsured. Screenings/assessments are universally available for children 0-3 whose families request them. If ineligible, referrals are provided to other community services. 100% of eligible children enrolled in EI receive services provided by practitioners in more than one discipline, as defined by an IFSP. MassHealth reimburses these services for enrolled children.

FIRSTLink connects families with pediatric health care providers, and provides information and referrals to families to address barriers to getting to health care appointments.

The EIPP provides periodic health assessments and follow-up through the child's first year. Access to and utilization of primary and specialty health care is a primary focus, and well-child care is a performance measure.

Family Planning is working in collaboration with Medicaid to develop a Medicaid waiver for family planning services. Meetings have begun with Medicaid and providers to explore options for expanding Medicaid coverage for family planning services to adolescents.

School-Based Health Centers provide a consistent source of primary health care in an accessible environment. SBHC standards stipulate that families must be offered assistance to determine their eligibility and enrollment in MassHealth. Preliminary data indicate over 6100 students served.

EOHHS has continued with its reorganization to streamline the administration of public insurance programs, including MassHealth, SCHIP, CMSP & the Free Care Pool and provide better coordination of care as a member moves from one program to another depending on eligibility criteria.

The EOHHS "virtual gateway" catalog, eligibility screening, and common application tools began to go live in July 2004. These tools give the public and providers streamlined access to multiple EOHHS services, including MassHealth, CMSP, Healthy Start, Women's Health Network, WIC, Substance Abuse Services, Food Stamps, and EI.

c. Plan for the Coming Year

Family Planning will continue to assist Medicaid to complete the family planning waiver request and submit to CMS for approval. If approved, the program will work to ensure its effective implementation in Massachusetts.

The staggered implementation of functionality for the EOHHS "virtual gateway" catalog, eligibility screening, and common application tools will continue into FY06, along with ESM/EIM functions. (See "Current Activities for more information about the virtual gateway.) Additional BFCH / MCH programs are expected to be either operational in the Virtual Gateway environment by the end of FY06 or scheduled for inclusion. As additional functions and programs are added, both improved access to and tracking of services for Massachusetts residents will become a reality. For example, pregnant women and young children who apply for MassHealth or foodstamps will be automatically referred to WIC.

Other current activities will continue from FY05.

Five SBHCs will continue to participate in a Kellogg-based initiative that includes as one of its objectives "to improve families' access to available health and social service resources". Activities will include collaboration with the Community Health Outreach Worker Program to improve recruitment, determination of eligibility and enrollment of vulnerable families to receive health services.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.36	1.44	1.48	1.52	1.5
Annual Indicator	1.3	1.4	1.4	1.4	1.4
Numerator	1090	1114	1109	1115	
Denominator	81582	81014	80624	80167	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.4	1.4	1.4	1.4	1.4

Notes - 2002

Data for both the numerators and denominators are taken from MDPH Vital Records for calendar years 1991 – 2001. This is the most recent year of data available. The denominators are all resident births for the relevant year.
Annual Performance Objectives through 2003 project a continued slight rise in the overall VLBW rate over the period; these projections have been adjusted to level out at 15.0 through 2007. The VLBW rate rose in 1997 and remained essentially unchanged through 2001; it remains higher than rates earlier in the 1990's.
Analysis indicates that this rise (and a rise in LBW as well) is associated in part with changes in the rate of multiple births (Cohen, BB, Friedman, DJ, Zhang, Z, Trudeau, EB. Impact of multiple births on low birthweight. Mortality and Morbidity Weekly Review 1998; 48: 289-292). Massachusetts has the highest multiple-birth rate in the country. However, the VLBW rates among singleton births (which is now an MCHB Health Status Indicator) has not improved in the same period either. This is an issue that we continue to address.

Notes - 2003

Data for both the numerators and denominators are taken from MDPH Vital Records for calendar years 1991 – 2003. This is the most recent year of data available. The denominators are all resident births for the relevant year.
Annual Performance Objectives through 2009 have been adjusted to level out at 1.4. The VLBW rate rose in 1997 and remained essentially unchanged since 2001; it remains higher than rates earlier in the 1990's.
Analysis indicates that this rise (and a rise in LBW as well) is associated in part with changes in the rate of multiple births; Massachusetts has the highest multiple-birth rate in the country. However, the VLBW rates among singleton births (which is now an MCHB Health Status Indicator) has not improved in the same period either. This is an issue that we continue to address.

Notes - 2004

2004 birth data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

a. Last Year's Accomplishments

See also activities reported in NPMs # 8, 9 and 18: SPMs # 1, 5, 6, 8, and 10; and Priority Need #1

EIPP services pregnant and post partum women in nine communities with some of the state's highest rates of infant mortality and morbidity. Of all 393 EIPP Participants, 9% experienced a previous poor birth outcome, 27% had a current high-risk pregnancy and 14% reported substance abuse in their home. All EIPP Participants are screened for alcohol, tobacco, and other drugs, with 32% being assessed at intake to have either a low or moderate level of strength in this area indicating a risk that prompted further examination and the provision of health education. Seven EIPP Mothers experienced a fetal/infant death.

"Perinatal Primary Care Program/Massachusetts Pregnancy Nutrition Surveillance 2002 Statewide Summary Data Report" indicates that the low birth weight for this program has remained fairly steady over the past 10 years at 7%.

A variety of smoking cessation programs were available across the Commonwealth, as part of statewide, regional, and community-based tobacco control services and activities, with many focusing especially on pregnant women and women with young children. (See also SPM #5.)

Substance abuse treatment for pregnant women and their families is provided through a number of models including outpatient, residential, shelters, and specialized detoxification services for pregnant women.

The Alcohol Screening and Assessment Program worked with prenatal care providers to strengthen capacity and skill in screening for substance use during prenatal care.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All programs that work with pregnant women screen for and assist with access to prenatal care		X		
2. Comprehensive prenatal care provided in 54 community health centers	X			
3. BFCH funds outreach, care coordination, and services not covered by insurance in 30 perinatal primary care sites	X	X		
4. Nutrition assessment/counseling is provided in perinatal care sites, in coordination with WIC		X		
5. WIC, in 159 sites statewide, provides nutritional assessment, counseling and food to pregnant women	X	X		
6. WIC and Primary care nutritionists screen and counsel women in nutrition and health risks, and refer for smoking cessation and other health and social service programs		X		
7. Training offered prenatal care providers in screening and brief intervention for substance use				X
8. Home Visiting programs assess for access to dental care and refer as appropriate		X		
9. Develop strategic plans in communities at risk to address perinatal disparities in preterm births and LBW rates				X
10.				

b. Current Activities

All BFCH programs that interact directly with pregnant women screen for access to prenatal care and enrollment in WIC, and make appropriate referrals and assistance with access as needed.

Community-based primary care sites provide comprehensive prenatal care with early identification, assessment and referral to high-risk perinatal care as indicated. An assessment is performed on every prenatal client to identify risk factors of pregnancy that may require special planning, consultation or referral. Patients are screened for and counseled on the use of alcohol, tobacco and other non-prescribed substances (ATOD). Care is family-centered and provided in the woman's primary language, when possible.

All pregnant women served by WIC receive a thorough nutrition assessment with the establishment of individualized care plans. Women are then prescribed and issued appropriate food packages. Women with poor weight gain patterns are monitored regularly and receive in-depth counseling and intervention plans. All prenatal women who smoke or resume smoking during pregnancy are referred to smoking cessation programs.

Participation in the second Boston Prematurity Summit in November 2004, in collaboration with the March of Dimes, the Boston Public Health Commission, Northeastern University, Boston University School of Public Health and Boston area community health centers. The Boston Prematurity Summit provides a multidisciplinary forum for providers, legislators, consumers and other members of the community about risk factors, racial and ethnic disparities and the long-

term consequences of prematurity.

EIPP home visitors provide periodic home visits to high risk pregnant and post partum women, conducting comprehensive health assessments, brief intervention and linkages to appropriate referrals sources. Screening and counseling for certain health indicators including substance abuse and current risk behaviors are core components of the program. Current data indicates that 27% of EIPP participants are experiencing a high-risk pregnancy, 9% with a history of previous poor birth outcomes, 18% reporting substance abuse in the home, and four fetal deaths.

The Office of Oral Health is currently working with the March of Dimes to provide information on the potential associations between oral diseases and perinatal outcomes: pre-term low-birth weight infants.

MDPH participated in the CDC/AMCHP-funded MATRICHS training to enhance capacity to use data to inform policy and programming in addressing perinatal disparities.

The perinatal disparities project is developing a statewide strategic plan and five community plans to address perinatal disparities in preterm birth and VLBW births.

c. Plan for the Coming Year

The Division of Perinatal and Early Childhood Health will continue collaboration with the Bureau of Substance Abuse Services to include FASD policies and FASD education and training for providers and staff in all BSAS residential programs for women and families.

Formalized coordination agreements between WIC and primary care are being implemented to ensure comprehensive, unduplicated timely nutrition services.

Analysis of factors related to VLBW such as multiple births will continue using the Pregnancy to Early Life Longitudinal (PELL) data system. Analysis of interpregnancy interval data in PELL as it relates to birth outcomes will continue, as will our work with Medicaid to encourage linkages with Medicaid data to births through PELL.

As a follow-up to CDC/AMCHP-funded MATRICHS training, a curriculum for community training in analyzing quantitative and qualitative local and state data will be developed to inform a strategic plan addressing racial disparities in birth outcomes. The training will be replicated in communities throughout Massachusetts.

Collaboration with the DPH Center for Health Information Research and Evaluation will continue to ensure racial, ethnic and language data are collected in compliance with DPH standards.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective	6.9	6	6	5	5
Annual Indicator	5.1	4.6	3.4	5.1	5
Numerator	21	19	14	21	
Denominator	415737	415737	415737	415737	
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	5	5	5	5	5

Notes - 2002

Data on deaths are taken from MDPH Vital Records for calendar years 1991 -2001. This is the most recent year of data available. Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The 2001 denominator is the same as the 2000 denominator, as no 2001 population estimates are yet available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) produces the standard population estimates used by the Department of Public Health.

Deaths in years 1999 and later are derived from ICD-10 codes (10th Revision of the International Classification of Diseases). Caution should be used in comparisons with previous years using ICD-9 codes.

Deaths in years 1999 and later are derived from ICD-10 codes (10th Revision of the International Classification of Diseases). Caution should be used in comparisons with previous years using ICD-9 codes.
The single year rates are quite volatile and year-to-year changes (either up or down) should not be over-interpreted. Expanded efforts to prevent suicides and suicide attempts that got underway in FY02 with new state funding lasted for approximately one year before being cut. Thus we are projecting the possibility of a rise in the rate over the next several years.

Notes - 2003

Data on deaths are taken from MDPH Vital Records for calendar years 1991 - 2003. This is the most recent year of data available. Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The denominators from 2001 forward are the same as the 2000 denominator, as no subsequent population estimates are available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) no longer produces the standard population estimates on a regular basis.

Deaths in years 1999 and later are derived from ICD-10 codes (10th Revision of the International Classification of Diseases). Caution should be used in comparisons with previous years using ICD-9 codes.

The single year rates are quite volatile and year-to-year changes (either up or down) should not be over-interpreted. Expanded efforts to prevent suicides and suicide attempts that got

underway in FY02 have only been funded intermittently in the state budget. We are projecting a level rate over the next several years.

Notes - 2004

2004 death data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

a. Last Year's Accomplishments

For the third year, MDPH received state funds to implement a suicide prevention program.

The Third Annual Suicide Prevention Conference, "Caring Communities Save Lives: Suicide Prevention Across the Lifespan" was held in May, 2004; attended by 330 providers and advocates.

Two QPR Gatekeeper Instructor Certifications and two Risk Management Trainings were held in Boston and Holyoke at no cost to 150 service providers and clinicians. Certified instructors agreed to train others.

100 school nurses attended a presentation on teen suicide put together in conjunction with the MDPH Injury Surveillance Program.

Samaritans of Boston and the DPH Elder Health Program presented a Suicide Prevention workshop to over 100 elder caregivers attending the statewide Councils on Aging Conference.

Staff participated in the activities of the Massachusetts Coalition for Suicide Prevention and provided technical assistance.

Staff from the Injury Prevention and Control Program, including the Suicide Prevention Program, participated on the EOHHS Suicide Prevention Task Force to address suicide prevention among the 504 Office for Child Care Services licensed 24 hour residential programs for children.

Staff continued work with Survivors of Suicide Advisory Council for the special needs of people who have lost a loved one to suicide.

Two suicide prevention training modules were completed and will be piloted in 2005.

In SBHCs, approximately 33% of visits of youth aged 15-19 involved screening for emotional/mental health indicators such as depression, suicidal ideation, and affect/stress. One-on-one counseling took place during 63% of these visits. SBHC clinical training has been offered in the area of screening for depression and the range of co-occurring disorders associated with an increased risk for suicidality.

Essential School Health Services sites reported 171,143 mental health encounters and 79% of districts offered at least one emotional health support group in FY04. 6,190 students attended a support group focussed on "Emotional/Psychologic" issues.

268 school nurses attended the UMass/Simmons School Health Summer Institute session on "Youth Suicides in Massachusetts" and 47 school nurses attended a program on mental health issues. The winter 2004 School Health Newsletter (circulation of 3,800 and on the web) focused on preventing intentional injuries and included an article on preventing suicides.

48% of the EIPP Participants served in FY04 reported a history of depression at intake. Of the 314 EIPP Participants who received an initial comprehensive health assessment, 79% were found to have either a low or moderate level of strength in the area of emotional health including post partum depression. 43 EIPP Participants were referred for long-term

counseling/mental health services while additional 34 EIPP participants were supported in maintaining their current connections with counseling/mental health services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening, treatment, and referral for depression and other MH issues offered in FIRSTLink, adolescent primary care, SBHCs, and many ESHS programs	X	X		
2. Supportive and Healthy Communities for Gay and Lesbian Youth Program (SHCGLY)		X	X	
3. Extensive training & TA to SBHC clinicians & school nurses in mental health and suicide screening and prevention				X
4. Implement pilot programs in 4 communities to address perinatal depression		X		X
5. Work with Coalition for Suicide Prevention to implement Suicide State Plan				X
6. Sponsor trainings, a conference, and seminars on suicide				X
7. Update resources including the Suicide Data Book & the Mass. Suicide Prevention Resource Guide			X	X
8. School nurses do assessment and referral for depression and other mental health issues for children in grades K-12. This is a requirement of the ESHS grants		X		
9. Screening, brief intervention and referral/linkage to long term care for depression and other MH issues offered in EIPP	X	X		
10.				

b. Current Activities

Five additional questions have been added to the BRFSS to gather information pertaining to the needs of Survivors; five questions about suicide attempts are repeated from 2004

45 Massachusetts schools have received SOS (Signs of Suicide) kits and 87 staff have been trained in how to implement the program.

Bi-monthly seminars on suicide prevention are scheduled throughout the year for various professional groups including: EMTs, Councils on Aging, Funeral Directors Association, PTAs and the Northeast Human Resources Association.

A Speaker's Bureau of QPR certified gatekeeper training instructors has been established. Approximately 400 individuals have received gatekeeper training including: Mass. NAMI statewide convention, DSS, Milton Council on Aging, residential staff of Advocates, EMTs, DMH staff and The Social Security Law Group.

The Massachusetts Strategic Plan for Suicide Prevention is being implemented through the Massachusetts Coalition for Suicide Prevention. Work on three goals is being supported by the program.

The 4th annual Suicide Prevention Statewide Conference, Taking Action, Saving Lives: Suicide Prevention Across the Lifespan, took place on May 17, 2005.

Staff participation continues on the EOHHS Suicide Prevention Task Force and the Massachusetts Youth Violence Prevention Partnership.

Technical assistance continues to the Massachusetts Coalition for Suicide Prevention, community groups and individuals.

The Suicide Prevention Resource Guide has been up-dated and will be available electronically on the Massachusetts Coalition for Suicide Prevention and MDPH websites.

The School Health Institute offers a workshop on mental health issues in school.

An area of special focus in the new SBHC funding cycle has been to increase access to and provision of mental and behavioral health services. Objectives include an increase in screening for depression and substance abuse and training for school staff in depression symptom recognition. Two surveys are currently being analyzed to determine both the mental health services integration needs and the staff development needs of SBHC clinicians.

FOR families staff provide crisis intervention and screening and referrals for depression and other mental health concerns for homeless families, including children and youth.

FIRSTLink and EIPP home visitors screen for depression and other mental health concerns, making referrals as appropriate. Current data indicates that 48% of EIPP Participants have a history of depression including postpartum depression.

The Essential School Health Services programs are incorporating the SOS program into the high schools to help identify students at risk for depression and suicide so referrals can be made.

Analysis of the MA youth health survey data on depression and suicide attempts among adolescents with disabilities was completed.

c. Plan for the Coming Year

Plans for FY06 are being developed, based on the final state budget. It is expected that activities will include: continuing support for the implementation of the state strategic plan; a fifth annual statewide suicide prevention conference; continued technical assistance for the Massachusetts Coalition for Suicide Prevention and the Youth Violence Prevention Partnership; development of a speakers bureau to respond to requests for suicide prevention training for mental health and substance abuse professionals; further support of a survivor outreach program; a program to encourage primary care physicians to diagnose depression; surveillance; evaluating the use of the SOS Suicide Prevention Program in schools and colleges; and continued QPR training of gatekeepers. Both the Department of Mental Health and the Department of Education are partners in the development of the plan.

The revised Comprehensive School Health Manual, which contains a chapter on mental health and suicide prevention, will be disseminated to schools and placed on the Department's website.

Through the Massachusetts Perinatal Connections Project, implement a program to 1) decrease stigma related to perinatal depression and other mental health issue; 2) build obstetric, pediatric, family practice and community provider capacity to identify women at risk for perinatal depression, provide appropriate intervention, and help them access services; and 3) implement and evaluate an innovative, sustainable model in four communities (Lowell, Somerville/Cambridge, Fitchburg and Springfield) to enhance the capacity to identify women at

risk for perinatal depression, provide a) individual home-based services, b) group services and/or c) referrals to community based services for women and their families.

Based on findings from surveys done in FY05, a clinical training plan for SBHC clinicians will be developed. One of the focus areas will be to foster greater competence in the area of prescribing and monitoring psychopharmacological medications.

With the Governor's Commission on Gay and Lesbian Youth, BFCH will continue to oversee Supportive and Healthy Communities for Gay and Lesbian Youth, a program designed to address suicide and violence against GLBT youth.

Participate on the Department of Mental Health Steering Committee to assure integration of stigma reduction and other activities related to suicide prevention across the two agencies.

Participate on an EOHHS interagency team to implement recommendations related to suicide prevention within state residential programs.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	90	90	90	85	85
Annual Indicator	89.3	86.9	86.0	86.1	86
Numerator	922	893	909	907	
Denominator	1032	1028	1057	1054	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	86	86	86	86	86

Notes - 2002

Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar years 1991 - 2001. The eight Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise. The addition of one regional Level II hospital to the group with NICUs beginning in 2002 will only modestly improve the rate, which has begun declining in all regions

of the state.
The Bureau continues to work with the Division of Health Care Quality, the Perinatal Advisory Committee, and other obstetric and neonatal clinicians to examine the question of appropriate care in Level II and Level III facilities. The Hospital Licensure Regulations for Maternal-Newborn Services (developed in the late 1980's) are being reviewed for potential updating and modification. Some Level II facilities are seeking changes in the regulations to allow them to provide certain services currently only allowed in Level III hospitals. The literature and experience are divided on the safety of some of these practices. Our capacity to monitor these changing patterns of policy (and potentially regulations) and their impact on both care and outcomes for VLBW infants is critical but resources remain constrained. A pilot study (done with Partners Healthcare) of performing short-term mechanical ventilation on infants over 32 weeks gestation at Level II facilities is being explored.

Notes - 2003

Data on VLBW, birth hospitals, and resident births are from MDPH Vital Records for calendar years 1991 - 2003. The eight Level III units are at Baystate Medical Center, Beth Israel Deaconess, Boston Medical Center, Brigham and Women's, Massachusetts General Hospital, Medical Center of Central Massachusetts, New England Medical Center, and St. Elizabeth's Medical Center. Data include only those resident births that occurred in-state at Massachusetts hospitals, as the birth file used for analysis does not contain the necessary information (specific hospital of birth) for births to residents at out-of-state facilities to be categorized by Level III facility. In one region of the state enough births occur out-of-state (in Rhode Island) to distort the statistic otherwise.
The addition of one regional Level II hospital to the group with NICUs beginning in 2002 (South Shore Hospital) only modestly improves the rate, which has begun declining in all regions of the state.
Revised Hospital Licensure Regulations for Maternal-Newborn Services have been prepared and are expected to formally promulgated by the end of 2005. Their impact on the perinatal regional system and the facilities considered to be appropriate for high-risk deliveries and neonates is unknown at this time. It is likely that new baselines will be established for 2006 births. The impact of the regulatory changes on the system and on the resulting data will be described in next year's annual report and monitored in future years.

Notes - 2004

2004 birth data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

Revised Hospital Licensure Regulations for Maternal-Newborn Services have been prepared and are expected to be formally promulgated by the end of 2005. Their impact on the perinatal regional system and the facilities considered to be appropriate for high-risk deliveries and neonates is unknown at this time. It is likely that new baselines will be established for 2006 births. The impact of the regulatory changes on the system and on the resulting data will be described in next year's annual report and monitored in future years.

a. Last Year's Accomplishments

Completed an assessment of current referral processes to determine the extent of expanded care developments at Level II facilities and whether such care capacity was affecting transfers to Level III facilities.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Community perinatal primary care sites have formal agreements with				X

tertiary care facilities				
2. Perinatal primary care providers screen for risk conditions & refer to appropriate level of care	X	X		
3. Data linkage/analysis to inform potential policy/regulations changes in hospital level requirements				X
4. Home visiting programs screen for risk conditions and refer to appropriate level of care		X		
5. Revisions to perinatal regulations to reflect current state of practice at Level II and Level III hospitals				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Late in FY05, revisions to state Hospital Licensure Regulations (105 CMR 130.000) governing maternal and newborn services were presented publicly; they are expected to be promulgated and go into effect in 2006. The proposed amendments represent the collaborative efforts of the Department's Center for Community Health, and Center for Quality Assurance and Control with input from the Center for Health Information, Statistics, Research and Evaluation and the Center for Communicable Diseases. For more than 18 months, the Department has been working with clinicians, hospitals, professional organizations and consumers on the comprehensive revisions. The Department of Public Health currently licenses 51 hospitals to provide maternal and newborn care plus one freestanding children's hospital providing newborn intensive care. With the advice of these individuals, organizations, the Perinatal Regulation Revision Task Force and several working groups, the proposed amendments are consistent with our goal to ensure mothers, newborns and their families have access to and receive quality care.

One of the critical areas addressed was appropriate care in Level II and Level III facilities, as the existing regulations did not reflect many of the advances in maternal-fetal medicine and neonatology since the 80's. Concerns have been growing about the smaller percentage of very low birthweight (VLBW) infants born in level III hospitals (83.4% in 2000 to 79.1% in 2003). The proposed amendments are designed to address issues such as these, in order to improve outcomes, and better serve families in the Commonwealth through more efficient provision of services to mothers and newborns.

More details about the proposed new regulations and a table summarizing key changes are included in the document attached to the NPM.

The question of appropriate care in Level II and Level III hospitals was investigated as part of the regulation revisions (see above), including using the PELL (Pregnancy to Early Life Longitudinal) data set. This year our CDC-resident epidemiologist contributed outcome data by hospital and hospital level-of-care to inform and help develop consensus among leading clinicians, hospital administrators, MDPH, and consumers about amendments to the MDPH hospital regulations governing maternal and infant care.

All contracted primary care sites that provide prenatal care must have formal collaborations with tertiary care hospitals for referrals and coordination of high-risk perinatal care.

PELL data linked to EI program data were analyzed to track appropriate referral by birthweight

and risks identifiable at birth. Analysis by level of hospital designation is underway and will be reviewed for appropriate referral of VLBW and other identifiable risks.

See also activities for NPM 15 re VLBW infants.

c. Plan for the Coming Year

The revised hospital licensure regulations for Maternal and Newborn Services should be officially promulgated in the first half of FY06. The MDPH will continue with our partners working for their smooth implementation and monitoring their impact on the perinatal regional system and on other aspects of maternal and newborn care.

In collaboration with Massachusetts NICU directors, who are interested in linking NICU data with EI, births, and other PELL data to improve short and longer-term outcomes for VLBW babies, continue to develop the Neonatal Quality Improvement Collaborative (NeoQIC). PELL data will be used to better understand the relationships between hospital-level designation and birth and early developmental outcomes. Incorporating PELL-based monitoring into perinatal regulations will be considered.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	84.22	84	84	84	85
Annual Indicator	82.1	83.7	83.7	83.3	83
Numerator	66952	67821	67457	66789	
Denominator	81582	81014	80624	80167	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	85	85	85	85	85

Notes - 2002

Data are from MDPH Vital Records for calendar years 1991 - 2001. This is the most recent year of data available.
The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB

definition reduces the calculated percentage slightly.
In 1996, Massachusetts implemented major revisions to the birth certificate form. While these format changes dramatically increased the consistency of data collection across facilities, the change affected several data elements, including calculation of the initiation of prenatal care. Trend analysis should be done from 1997 forward only.
The continued lack of significant improvement in this measure continues to be of concern and will remain a focus in FY04.

Notes - 2003

Data are from MDPH Vital Records for calendar years 1991 – 2003. This is the most recent year of data available.
The percentages shown differ from those published elsewhere, due to how missing data are handled. The MCHB definition of the denominator is specified as all resident births during the referenced year. In MassCHIP and most Massachusetts publications (such as Massachusetts Births), percentages are reported only for cases where information is known (i.e. the denominator excludes births for which data on the variable are missing). Using the MCHB definition reduces the calculated percentage slightly.
The continued lack of significant improvement in this measure continues to be of concern and will remain a focus in FY06.

Notes - 2004

2004 birth data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

a. Last Year's Accomplishments

The annual Partners in Perinatal Health Conference highlighted effective strategies for community outreach to engage women in timely prenatal care, creating a forum for addressing barriers racial and ethnic minorities face.

54% of the EIPP participants served in FY04 reported receiving their first prenatal care visit in the first trimester. Also, 30 EIPP Participants were referred for prenatal care services while an additional 109 EIPP participants were supported in maintaining their current connections with prenatal care services. However, only 35% of EIPP Participants served in FY04 received adequate prenatal care as measured with the Adequacy of Prenatal Care Utilization Index. EIPP Home Visitors report multiple barriers to ensuring consistent access and utilization of prenatal services including lack of transportation and child care services.

"Perinatal Primary Care Program/Massachusetts Pregnancy Nutrition Surveillance 2002 Statewide Summary Data Report" indicates that 75% of CPCP Perinatal program women entered care in the 1st trimester, a general trend since 1992 when 63.8% entered in 1st trimester.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Prenatal care provided in 30 community-based primary care sites	X			
2. WIC services in 159 sites statewide refer for prenatal care at first contact with pregnant women		X		
3. Worcester and Boston federal Healthy Start programs integrated with BFCH programs and services	X			X
4. Forum established to identify barriers to getting early care				X
5. EIPP provides assistance with accessing prenatal care and optimizing				

health benefits		X		
6. Offer community outreach to pregnant women to encourage early enrollment in EIPP		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Healthy Start Program has been transferred from DPH to the EOHHS, MassHealth Office of Acute and Ambulatory Care. The incorporation of the HSP program with other MassHealth programs will ensure that HSP members will benefit from all quality improvement measures and projects implemented by MassHealth for prenatal care.

First trimester enrollment in prenatal care is a contract performance measure for perinatal primary care sites (CPCP). Similarly, the percent of pregnant women enrolled in WIC early in pregnancy is also a contract performance measure. The coordination between WIC and perinatal primary care sites includes a protocol for cross-referrals to ensure early entry to both WIC and prenatal care.

Division of Perinatal, Early Childhood and Special Health Needs, Division of Primary Care and Health Access, and WIC staff participate in the MassHealth Perinatal Quality Improvement Project to examine ways to improve and enhance quality of prenatal health care of MassHealth/WIC participants.

In FY04, CMS approved MassHealth's SCHIP inclusion of "unborn children" for the Healthy Start Program. In October 2003, the MBR became the single application for both HSP and MassHealth. This has ensured that the majority of women at or below 200% FPL who were pregnant and would not otherwise qualify for MassHealth were identified and enrolled in HSP.

CPCP nutrition services are provided by Registered Dietician (mandated for high-risk) or WIC nutritionist including a complete initial nutrition assessment, education and individualized care plan and counseling, referrals to other related services, and follow-up visits according to American Dietetic Association protocol. High-risk perinatal clients will receive intensive nutritional services provided by an RD. Food security is assessed and appropriate referrals are made.

Adequacy of Prenatal Care Utilization Index is a contract performance measure for the EIPPs and improving this measure is a priority for the programs.

c. Plan for the Coming Year

Current, on-going activities will continue from FY05.

A major focus will be implementation of new state performance measures related to reducing perinatal disparities.

Carry-out further analysis of the characteristics of women delivering early and/or entering care in their fourth month (e.g. plurality, ethnicity, other risks) and pregnancy outcomes.

The current MDPH-funded perinatal primary care programs will be reassessed with the likely development of a new model. Ensure that the programs address health disparities by assessing the adequacy of current model and developing appropriate community based

models.

Examine, through the MATRICHS process, factors that contribute to the excess of fetal and infant deaths among black births in Massachusetts and build upon lessons learned from the AMCHP-ALL to decrease racial disparities in birth outcomes by developing state and community specific strategic plans to address these disparities. Collaborate with Boston and Worcester Healthy Start Initiatives to develop a statewide network for sharing promising practices and successful strategies for addressing racial disparities in birth outcomes.

Collaborate with Family Planning programs, WIC and MassHealth to identify structural strategies to increase early enrollment and target groups and areas with high disparities in early care.

Create a forum as an ongoing structural mechanism to identify barriers that delay care and lead to disparities and strategies that show promise in addressing infant mortality and poor birth outcome disparities.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percentage of pregnancies among women age 18 and over that are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	70	70	72	72	75
Annual Indicator	73.3		75	75	75.6
Numerator					
Denominator					
Is the Data Provisional or Final?				Provisional	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	76	78	78	78	78

Notes - 2002

The data for the measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS). See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance. Although the 2000 and 2002 BRFSS survey results exceeded our expectations, annual Performance Objectives for 2003 forward have been lowered slightly, in anticipation of the effect of substantially reduced state funding for family planning and teen pregnancy prevention services.

Notes - 2003

The data for the measure are available every other year from the Massachusetts Behavioral

Risk Factor Surveillance System (BRFSS); the next survey data will be for 2004. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance. Although the 2000 and 2002 BRFSS survey results exceeded our expectations, annual Performance Objectives for 2003 forward have been lowered slightly, in anticipation of the effect of substantially reduced state funding for family planning and teen pregnancy prevention services.

Notes - 2004

The data for the measure are available every other year from the Massachusetts Behavioral Risk Factor Surveillance System (BRFSS); the current survey data are for 2004. See the Detail Sheet (in Form 16) for this measure for definitions, data source and issues, and a discussion of its significance. The 2000, 2002, and 2004 BRFSS survey results exceeded our expectations (only slightly in FY04), and our annual Performance Objectives for 2005 and beyond have been raised.

a. Last Year's Accomplishments

Family planning services greatly reduced due to funding reductions. 31,991 clients were served, a 40% decrease from fiscal year 03.

Initiated a statewide RFR needs assessment process for family planning in preparation for RFR to be released in fiscal year 2005. Primary and secondary data was collected. Conducted internal and external RFR advisory groups to assist with the development of the family planning RFR.

BFCH completed one year of a pilot sharing arrangement among hospital physicians to improve women's access to termination services statewide. There were 275 calls for assistance during the first year of the project with the volume of calls increasing each month.

Massachusetts was chosen to be one of 5 states to participate in a 3-day workshop in June 2004 on Providing Access to Emergency Contraception Through State Programs and Systems sponsored by PATH (Program for Appropriate Technology in Health) and the state of Washington. Staff from the BFCH, Medicaid and community partners attended from MA.

Of the 314 EIPP Participants who received an initial comprehensive health assessment, 67% were found to have either a low or moderate level of strength in the area of reproductive health and family planning indicating a risk that prompted further examination and the provision of health education. Also, 52 EIPP Participants were referred for family planning services while an additional 17 EIPP participants were supported in maintaining their current connections with family planning services.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Reproductive health care is provided through a statewide family planning provider system	X			
2. Reproductive health services are also provided through primary care sites and School Based Health Centers (SBHC)	X			
3. Ongoing assessment of effects of closure of multiple sites due to funding reductions; produce Family Planning RFR and Family Planning Needs Assessment				X
4. Work to assure continuation of availability of basic reproductive health care				X

5. Family Planning standards are set by MDPH; programs are monitored for adherence				X
6. Maintain an Abstinence Education media campaign			X	
7. Home visiting programs provide education, counseling, and referral to family planning services		X		
8. Increase access to emergency contraception		X		
9. Collaborate with BSAS in youth substance abuse prevention and services				X
10. Improve surveillance through questions added to the BRFSS			X	X

b. Current Activities

Reproductive health clinical services are provided to families in need through a system of family planning agencies. Services include comprehensive exams, pregnancy testing and options counseling, counseling on reproductive health issues, contraceptive provision including access to emergency contraception, STD counseling, testing, diagnosis and treatment, HIV prevention and education, and referrals to related services such as primary care.

Staff conduct regular program monitoring and provide technical assistance to family planning agencies to ensure compliance with program standards, completed vendor site assessments in fall 2004 and hold biannual meetings and share information via the provider list serve.

The Emergency Contraception Network provides a forum to improve access to and public knowledge of emergency contraception. A full-time coordinator coordinates all activities. The network is providing training, technical assistance and educational materials to community health centers and other providers.

Family planning providers, advocates and pharmacists are working together to support legislation that would expand access to emergency contraception for all women through pharmacists via collaborative agreements with physicians and to rape victims in emergency rooms.

BFCH staff coordinate and manage the Abortion Advisory Committee, which provides a forum for clinicians, health care organizations, public health advocates and government agencies to advise the DPH on the implementation of legislative mandates and on strategies that support reproductive healthcare and reduction of unintended pregnancy.

Family Planning has initiated a process in collaboration with Medicaid to develop a Medicaid waiver for family planning services. Meetings have begun to explore options for expanding Medicaid coverage for family planning services to all men and women who are income eligible or who may loose Medicaid coverage.

Family Planning RFR and Needs Assessment developed and released January 2005 to re-procure family planning funding (start date July 1, 2005) with the goal of focusing services to populations and communities most at risk of unintended pregnancy and STDs. Revised program standards and a billing manual were also released.

Planning and development of 2006 BRFSS questions.

FOR Families, EIPP, and FIRSTLink home visitors assess women to determine if they have adequate/appropriate family planning information, with referrals/follow-up made to family planning or primary care providers. All contracted primary care sites must provide/arrange for comprehensive family planning services.

c. Plan for the Coming Year

NOTE: This State Performance Measure, slightly modified, will continue into FY06 and beyond.

Current on-going activities will continue from FY05.

Family Planning will assist Medicaid to complete family planning waiver request and submit to CMS for approval. If approved, the program will work to ensure its effective implementation in Massachusetts.

Implement process to review and revise all birth control brochures and to expand website.

Revise MDPH regulations to allow for the distribution of designated medications with state-funded family planning programs by designated staff.

State Performance Measure 3: *Percent of children and youth enrolled in Medicaid, CMSP, or Title XXI who receive any preventive (well-child) services annually.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	50.	66	67	68	69
Annual Indicator	66.0	63.7	63.2	67.1	73.1
Numerator	270334	288103	289250	310832	294205
Denominator	409583	452559	457875	463305	402681
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416; the most recent data are from the period October 1, 2001 - September 30, 2002. Rates, but not the underlying numbers, for years prior to FY1997 were available from DMA. In FY99, HCFA revised the 416 report and the visit codes that are allowable for Medicaid to count the visit as a "screen;" data prior to FY99 should not be compared to data from FY99 forward.

Data from the state-funded Children's Medical Security Program (CMSP) were added to the numerator and denominator beginning in FY00. CMSP enrolled children and youth represent 43,419 of the total denominator shown for FY02. The percent of CMSP children and youth receiving documented preventive services has increased modestly, from 24% in FY00, 26% in

FY01, to 30% in FY02. The percent of Medicaid children and youth remained level in FY02 at 67%.

To date, the CMSP billing and data systems (which are distinct from Medicaid's) do not have the capability to fully capture the equivalent of the HCFA 416 report. Preventive services provided during a "sick visit" are not fully captured in billing codes and thus are partially missing from the composite data. It should also be noted that the average amount of time that children are continuously enrolled in CMSP in any given year is only about 9 months and there is a substantial amount of on and off enrollment as families gain or lose private insurance or change their eligibility status. These patterns of enrollment, unfortunately, make achieving the preventive potential of the program more difficult; some preventive activities may have been carried out through the other insurers as well.

Notes - 2003

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416; the most recent data are from the period October 1, 2002 - September 30, 2003. Rates, but not the underlying numbers, for years prior to FY1997 were available from DMA. In FY99, HCFA revised the 416 report and the visit codes that are allowable for Medicaid to count the visit as a "screen"; data prior to FY99 should not be compared to data from FY99 forward.

Data from the state-funded Children's Medical Security Program (CMSP) were added to the numerator and denominator beginning in FY00. CMSP enrolled children and youth represent 42,619 of the total denominator shown for FY03. The percent of CMSP children and youth receiving documented preventive services has increased modestly, from 24% in FY00, 26% in FY01, to 30% in FY02, before leveling off at 28% in FY03. The percent of Medicaid children and youth rose in FY03 from 67% to 71%.

To date, the CMSP billing and data systems (which are distinct from Medicaid's) do not have the capability to fully capture the equivalent of the HCFA 416 report. Preventive services provided during a "sick visit" are not fully captured in billing codes and thus are partially missing from the composite data. It should also be noted that the average amount of time that children are continuously enrolled in CMSP in any given year is only about 9 months and there is a substantial amount of on and off enrollment as families gain or lose private insurance or change their eligibility status. In FY03, there were also caps on enrollment and waiting lists were implemented. These patterns of enrollment, unfortunately, make achieving the preventive potential of the program more difficult; some preventive activities may have been carried out through the other insurers as well.

Notes - 2004

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416; the most recent data are from the period October 1, 2003 - September 30, 2004. Rates, but not the underlying numbers, for years prior to FY1997 were available from DMA. In FY99, HCFA revised the 416 report and the visit codes that are allowable for Medicaid to count the visit as a "screen"; data prior to FY99 should not be compared to data from FY99 forward.

Data from the state-funded Children's Medical Security Program (CMSP) were added to the numerator and denominator beginning in FY00. However, the FY04 data are only for Medicaid, as FY04 data on CMSP enrolled children and youth are not yet available. With the transfer of CMSP out of the BFCH in FY05, data management and analysis functions were transferred as well and our ability to readily generate or obtain these data has been reduced. The percent of CMSP children and youth receiving documented preventive services did increase modestly, from 24% in FY00, 26% in FY01, to 30% in FY02, before leveling off at 28% in FY03. The

percent of Medicaid children and youth has also increased, from 67% in FY02, to 71% in FY03, and to 73% in FY04. Because Medicaid has historically shown higher percentages of preventive services use, the apparent improvement in the reported rate for FY04 is an artifact of the lack of CMSP data at this time and should not be regarded as a trend.

Even when the data have been available, the CMSP billing and data systems (which are distinct from Medicaid's) do not have the capability to fully capture the equivalent of the HCFA 416 report. Preventive services provided during a "sick visit" are not fully captured in billing codes and thus are partially missing from the composite data. The average amount of time that children are continuously enrolled in CMSP in any given year is only about 9 months and there is a substantial amount of on and off enrollment as families gain or lose private insurance or change their eligibility status. In addition, in FY03 there were also caps on enrollment and waiting lists were implemented. These patterns of enrollment, unfortunately, make achieving the preventive potential of the program more difficult; some preventive activities may have been carried out through the other insurers as well.

Because of these multiple data issues, which are unlikely to be improved, this measure is being eliminated entirely as part of our 5-year needs assessment and establishment of new State Performance Measures.

a. Last Year's Accomplishments

28% of CMSP clients received preventive services, identified by ICD codes for preventive visits and ICD for sick visit if accompanied by a preventive service modifier. Many providers who provide annual preventive services when a member accesses sick visits do not provide the preventive service modifier. Therefore, the percentage accessing preventive services reflected might undercount what is truly accessed.

In FY04, approximately 16% of SBHC visits to publicly insured children and youth ages 1-19 involved a preventive health service (based on reported procedure or diagnostic code).

EIPP and FIRSTLink home visitors stress the importance of preventative health care with parents and information and printed materials were provided as appropriate. Referrals to local primary health care services were made and assistance with access to care was provided.

See also NPM # 14 regarding well child chart audits in CPCP sites.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All BFCH programs that work with children assess for ongoing linkage to preventive/primary health care		X		
2. SBHC clinicians receive ongoing training in barriers to access to and utilization of care				X
3. All BFCH programs that work with children assess for ongoing linkage to preventive/primary health care		X		
4. See activities for NPM 13 & 14, and NPM 3 & 4 for CSHCN related to MassHealth and preventive care.		X		
5.				
6.				

7.				
8.				
9.				
10.				

b. Current Activities

See NPPM #13 and #14 also.

CMSP was transferred from DPH to the Executive Office of Health and Human Services, MassHealth Office of Acute and Ambulatory Care. The incorporation of the CMSP program with other MassHealth programs will ensure that the children will benefit from all quality improvement measures and projects implemented by MassHealth for preventive services.

School-based Health Centers (SBHC) sites are funded by prioritizing communities with documented limited access to primary care and high rates of poverty, using criteria deemed to serve as proxies for "vulnerability."

All WIC infants and children are assessed for on-going primary health care and immunization needs at each WIC certification/recertification visit. Referrals are made to health providers as necessary.

FOR Families, FIRSTLink, and EI Partnership Program (EIPP) programs assess children and youth to determine if they are enrolled in MassHealth or CMSP. They also assess the need for preventive [well-child] services, make referrals and conduct follow-up to ensure that well-child services are received as recommended according to the age of the child.

In conjunction with the SBHC program, five communities participated in a Kellogg-sponsored initiative to improve access to available health services.

c. Plan for the Coming Year

This measure (or a close variant of it) will not be included in our State Performance Measures in future years. Therefore, no Plans for the Coming Year are included.

State Performance Measure 4: *Percent of children and youth (ages 3 - 18) enrolled in Medicaid or CMSP who receive preventive dental services annually.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	27.0	45	45	60	37
Annual Indicator	45.7	53.4	62.0	35.9	41.8
Numerator	181869	208349	243889	149548	166294
Denominator	398003	390479	393577	416144	398185
Is the Data					

Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	40	40	40	40	40

Notes - 2002

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416; the most recent data are from the period October 1, 2001 - September 30, 2002. The 416 report now reports data in more detail than previously by children's age. Beginning with the FY99 data, the measure was modified to include data on children ages 3 - 18 only.

Data from the state-funded Children's Medical Security Program (CMSP) were added to the numerator and denominator beginning in FY00. CMSP enrolled children and youth represent 43,419 of the total denominator shown for FY02. CMSP coverage for dental services began during FY00 and the number with claims paid for dental visits was quite small (1,824, or 5%). By FY01, those with claims rose to 8,435, or 23%, and to 10,421 or 24% in FY02. The numbers in future years should continue to rise, if funding allows continuation of the benefit. It should also be noted that the average amount of time that children are continuously enrolled in CMSP in any given year is only about 9 months and there is a substantial amount of on and off enrollment as families gain or lose private insurance or change their eligibility status. These patterns of enrollment, unfortunately, make achieving the preventive potential of the program more difficult and some preventive activities may have been carried out through the other insurers as well.
The percentage of Medicaid children and youth receiving preventive dental services has continued to rise (50% in FY00, 57% in FY01, and 67% in FY02), reflecting a number of positive changes: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives.

Notes - 2003

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations.

The data correspond to those reported by the Commonwealth to HCFA on Form HCFA 416; the most recent data are from the period October 1, 2002 - September 30, 2003. The 416 report now reports data in more detail than previously by children's age. Beginning with the FY99 data, the measure was modified to include data on children ages 3 - 18 only.

Data from the state-funded Children's Medical Security Program (CMSP) were added to the numerator and denominator beginning in FY00. CMSP enrolled children and youth represent 42,619 of the total denominator shown for FY03. CMSP coverage for dental services began during FY00 and the number with claims paid for dental visits was quite small (1,824, or 5%). Since then those with claims has remained at 23 – 24% (9,789 in FY03). It should also be noted that the average amount of time that children are continuously enrolled in CMSP in any given year is only about 9 months and there is a substantial amount of on and off enrollment as families gain or lose private insurance or change their eligibility status. In FY03, there were also caps on enrollment and waiting lists were implemented. These patterns of enrollment, unfortunately, make achieving the preventive potential of the program more difficult and some preventive activities may have been carried out through the other insurers as well.

The reported percentage of Medicaid children and youth receiving preventive dental services

continued to rise (50% in FY00, 57% in FY01, and 67% in FY02), before dropping significantly in FY03 to 37%. The increased rates may have reflected a number of positive changes: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives. The apparent drop, however, is due to a major correction in the data reporting methodology. We have been informed by Medicaid that the previous methodology overestimated rates of preventive dental services utilization and that they needed to change it. The previous years' data need to be recalculated for a more accurate time series and we are in the process of working with Medicaid to option the corrected data if possible. In the meantime, no trend analyses can be made from the data in hand. We have also adjusted our projected Objectives through FY08 to reflect the modified methodology and the likelihood that our progress on this measure is not what we had thought it was.

Notes - 2004

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of data limitations. The data correspond to those reported by DMA to HCFA on Form HCFA 416; the most recent data are from the period October 1, 2003 - September 30, 2004. The 416 report now reports data in more detail than previously by children's age. Beginning with the FY99 data, the measure was modified to include data on children ages 3 - 18 only.

Data from the state-funded Children's Medical Security Program (CMSP) were added to the numerator and denominator beginning in FY00. CMSP coverage for dental services began during FY00 and the number with claims paid for dental visits was quite small (1,824, or 5%). Since then those with claims remained at 23 – 24% and then rose to an estimated 64% in FY04. These are estimated percents, as CMSP cannot provide an unduplicated count of clients, only visits. Because CMSP allows two dental visits per year, we have made a conservative estimate by dividing the total number of visits for children ages 3 -18 (44,670) by 2. It should also be noted that the average amount of time that children are continuously enrolled in CMSP in any given year is only about 9 months and there is a substantial amount of on and off enrollment as families gain or lose private insurance or change their eligibility status. In FY03, there were also caps on enrollment and waiting lists were implemented. These patterns of enrollment, unfortunately, make achieving the preventive potential of the program more difficult and some preventive activities may have been been carried out through the other insurers as well.
The percentage of Medicaid children and youth receiving preventive dental services continued to rise (50% in FY00, 57% in FY01, and 67% in FY02), before dropping significantly in FY03 to 37%. The increases may have reflected a number of positive changes: improved payment rates, increased recruitment of dentists, increased pediatric dental services available at community health centers, and increased promotion of the importance of dental care through a number of initiatives. The apparent drop, however, is due to a major correction in the data reporting methodology, as the previous one overestimated rates of preventive dental services utilization. Thus trend analysis should be done from FY03 forward only.

Due to the data issues discussed above and the fact that CMSP is no longer administered by the Title V agency, this measure is being modified as a result of our 5-year needs assessment and establishment of new State Performance Measures. The new measure will track only Medicaid clients, for which unduplicated counts of children receiving services are already being reported in a standardized manner.

a. Last Year's Accomplishments

Services helped to support the purchase of portable dental equipment for these programs. The Office of Oral Health also facilitated the development of community linkages between CHC dental clinics, local Medicaid dental providers and school health services. Staff worked with school nurses and ESHS Nurse Leaders to implement dental sealant programs in targeted at-risk communities.

Analysis of the 2003 Statewide Oral Health Survey of Third Grade school children revealed that 54% of Massachusetts' third-graders have at least one dental sealant. The survey identified gaps in service and areas where school-based sites could potentially increase access to preventive services for Medicaid and CMSP enrolled children.

Approximately 28% of Medicaid eligible children under age 21 received dental services; this percentage includes members aged 0-3.

27% of CMSP Enrollees aged 4-18 received dental services. Since CMSP is often used between instances of private health insurance coverage and MassHealth, many of the enrolled CMSP children may have already had dental preventive services.

The three hygienists hired by the Office of Oral Health have each worked with their respective groups -- Head Start, CSHCN and School-Health Services -- to increase access to oral health care services. They provided TA and worked collaboratively with community groups and nurse leaders to improve oral health outcomes.

A partnership between the Massachusetts Head Start agencies and the Office of Oral Health was established. Two Head Start oral health forums were held and a statewide oral health survey of Head Start children was conducted. Over 1,300 children were screened. Information on the survey and other activities are listed in the following section.

A partnership among the New England states Offices of Oral Health and Delta Dental has produced an oral health video targeting Head Start families. The specially designed video provides Head Start parents and caretakers with information on the "first dental visit."

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Office of Oral Health coordinates and provides leadership for oral health planning and activities				X
2. Training and TA are provided to school nurses and SBHC clinicians re: screening for oral health needs				X
3. WIC distributes dental health education materials & child toothbrushes				X
4. CHCs, SBHCs, ESHS, and other pedi primary care sites screen for oral health needs, and refer for care		X		
5. Many CHCs and some SBHCs and ESHS sites offer preventive oral health care on site.	X			
6. EIPP, FIRSTLink, and FOR Families assess and refer children for oral health needs		X		
7. See activities under NPM #9 also.				
8.				
9.				
10.				

b. Current Activities

School-based dental sealant programs operate statewide in over fifty schools in Massachusetts with fourteen new sites established this year in Boston.

The Office of Oral Health (OOH) collaborates with Essential School Health Nurse Leaders (ESHNL) to identify children who do not have access to dental services. The Office provides TA and training to ESHNL in using the Basic Screening Survey protocol, a dental screening program designed for use by non-dental health professionals to identify oral health needs.

The OOH continues to collaborate with the MassHealth Dental Program to identify strategies to improve access and utilization of preventive services.

Recognizing the value of SBHCs as a potential site for increasing access to dental care for low-income children, OOH offers clinical training to N.P.s. A presentation "School-Based Dental Health/Oral Health Screening Training" offers 'hands-on' training for the identification of children requiring sealants and/or further oral health evaluation.

The Office continues to collaborate with the state's Head Start agencies to develop a state action plan to improve the oral health of Medicaid and CMSP eligible children. Survey data are being used to identify gaps in care. Models for education, prevention and access are being developed. Tufts Univ. School of Dental Medicine has joined the partnership providing dental examination and prevention care on-site at Head Start agencies. Additional models of dental service delivery are being explored to address special access to care issues.

The hygienist consultant to CSHCN is working with the Care Coordination Program and the MA Consortium for CSHCN and others to better understand the special oral health needs for CSHCN. Development of a strategic plan to address the oral health needs of CSHCN is planned.

Dental health education materials, complemented with child toothbrushes, are provided to children enrolled in WIC. Children in need of dental care are referred to appropriate resources. FOR Families home visitors assess MassHealth-enrolled children and youth to determine if they receive preventive dental care, with referrals/follow-up to ensure that preventive dental services are received.

See also NPM # 7.

c. Plan for the Coming Year

A modified version of this State Performance Measure will be included in our new measures.

Using data from the two recent oral health surveys, the Office of Oral Health will collaborate with key stakeholders to complete the state oral health plan for Head Start/Early Head Start children, CSHCN and low-income Medicaid and CMSP eligible children.

The hygienist consultant to CSHCN will continue to work with the Care Coordination Program, Family TIES, and the MA Consortium for CSHCN to develop models for implementation of the strategic plan.

The Office of Oral Health plans to expand dental sealant programs to schools and communities identified in the 2003 Oral Health Survey where the percentage of children with at least one dental sealant is less than the state average.

Plans to expand school-based health center capacity to provide comprehensive dental services remain uncertain, due to budget reductions, the effects of reprocurement and the closure of some sites. Oral health will remain a priority, but which SBHCs will have the capacity to provide dental services on-site remains to be seen.

The Office will also collaborate with the Office of Acute and Ambulatory Care (Medicaid) to investigate the potential for a third party administrator for the MassHealth Dental Program

FOR Families, EIPP, FIRSTLink and Perinatal Connections home visitors will assess and refer or follow-up with families to ensure that children and youth enrolled in Medicaid or CMSP receive preventive dental care.

State Performance Measure 5: *The percent of women who report not smoking during their current pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	89.25	89.5	89.75	91	91
Annual Indicator	89.8	90.6	91.9	85.5	86
Numerator	73289	73420	74061	68551	
Denominator	81582	81014	80624	80167	
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	91	91	91	91	91

Notes - 2002

Maternal smoking during pregnancy and resident birth data are from MDPH, Vital Records for calendar years 1991 - 2001. This is the most recent year of data available.
See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data. Our target is the Healthy People 2010 rate of 90%.
The rates on Form 11 may differ from those published elsewhere, due to how missing data are handled. For comparability with other MCH Core Performance Measures related to pregnancy outcomes and birth statistics, we have defined the denominator for this Negotiated Measure as all resident births during the referenced year. In other Massachusetts publications (such as Massachusetts Births), percentages are usually reported based on denominators from which birth records with information missing about the variable have been removed. The result is a lower apparent rate. The differences are generally small but were more pronounced for 1996, when the impact of implementation of major revisions to the birth certificate form and transmission system resulted in a significantly higher rate of unknown values for some variables, including tobacco use, than in previous years.

Notes - 2003

Maternal smoking during pregnancy and resident birth data are from MDPH, Vital Records for calendar years 1991 - 2003. This is the most recent year of data available.

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data. Early success has slowed or reversed in the last two years, as funding for tobacco control activities has been uncertain and was significantly reduced. Funding has become stabilized again, but at a lower level, and we believe that our target levels are achievable.
The rates on Form 11 may differ from those published elsewhere, due to how missing data are handled. For comparability with other MCH Core Performance Measures related to pregnancy outcomes and birth statistics, we have defined the denominator for this Negotiated Measure as all resident births during the referenced year. In other Massachusetts publications (such as Massachusetts Births), percentages are usually reported based on denominators from which birth records with information missing about the variable have been removed. The result is a lower apparent rate.

This measure will remain as a State Negotiated Performance Measure for 2006 and beyond.

Notes - 2004

2004 birth data are not available. We have estimated a similar rate to that for 2003. See 2003 for the most recent data and see the Note for 2003 for data sources and other comments.

This measure will remain as a State Negotiated Performance Measure for 2006 and beyond.

a. Last Year's Accomplishments

The QuitWorks program, a collaboration of the Department with all major plans linking providers and their patients who smoke to the state's cessation services, continued to promote services and materials tailored for pregnant women who smoke.

A QuitWorks Pediatric task group adapted the QuitWorks program for pediatric practices, with a focus on the family. The program was piloted in pediatric practices prior to launch in FY 2005. The QuitWorks program was adapted for use in Massachusetts hospitals: 17 adopted the program in 2004 in many units, including some neonatal units.

Twenty percent (20%) of EIPP participants served in FY04 reported tobacco use at the time of intake. Of the 314 EIPP Participants who received an initial comprehensive health assessment, 41% were found to have either a low or moderate level of strength in the area of alcohol, tobacco, and other drug use indicating a risk that prompted further examination and the provision of health education. Also, 7 EIPP participants were referred for smoking cessation services while an additional 3 EIPP participants were supported in maintaining their current connections with family planning services.

85.5% of women in the CPCP Perinatal program reported not smoking and of the 15% who reported currently or recently smoking, 43% reported that they quit prior to or during their first trimester of pregnancy.

In FY04, among 148 SBHC visits to female clients (ages 15-19) who were pregnant or had recently delivered, 49 visits involved screening/counseling for alcohol, tobacco or other drug use.

In 53% of the 103 Essential School Health Services (ESHS) districts, 25,629 students and 929 adults participated in tobacco use prevention education groups; 1,694 such groups were held. In 27 districts, 347 smoking cessation group meetings were held; 4,174 students and 177 adults participated. In 70 districts, 4,039 students and 604 adults received individual counseling; and in 39 districts, referrals to other prevention/cessation services were made for 463 students and 141 adults.

Seventy-one high school nurses were trained in the school nurse-individual intervention tobacco cessation program developed and studied by the UMass Medical Center with funding

from BFCH.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Perinatal primary care providers screen and counsel pregnant women and refer to smoking cessation services	X	X		
2. Training and TA are provided to prenatal care providers on screening and brief intervention for substance use				X
3. WIC, EI Partnerships, and Perinatal Connections assess pregnant women for smoking, and counsel and refer to smoking cessation services	X	X		
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Tobacco Control Program serves women of childbearing age and children through state and local programs. Local tobacco control programs seek to protect children from the harmful effects of secondhand smoke through smoke-free home campaigns, education and outreach, and enforcement of local regulations around the sale of tobacco products. Tobacco treatment services are offered through a statewide Helpline and website for smokers, and the QuitWorks program, a collaboration of the Department with all major plans linking providers and their patients who smoke to the state's cessation services. Services and materials tailored for pregnant women who smoke are available.

Birth certificate data were analyzed to identify the municipalities where a higher proportion of pregnant women smoke. These findings were instrumental in the decision to launch the "Ready, Set, Quit" initiative in Fall River and New Bedford. This initiative encouraged smokers to call the quitline and receive free nicotine patches in addition to telephone cessation counseling. Significant partners in this project included the mayors of both cities, community groups, 5 large employers, hospitals, community health centers, and 3 health plans. Hundreds of clinicians in hospitals, practices, public health programs promoted the pilot and encouraged patients, including women with children and pregnant women, to quit smoking. Over 2000 smokers participated in the project and received cessation services.

The pediatric QuitWorks CEASE program was launched with partners to assist pediatric practices intervene with parents and adolescent who smoke and refer them for treatment. QuitWorks has been implemented in the neonatal unit at Mass General where post-partum women who smoke are referred to the quitline.

SBHC clinicians are trained how to use problem-oriented screening instruments and effective clinical interventions to address identified risks, including tobacco use. Clinical training is offered through the JSI Research and Training Institute on counseling pregnant women students who smoke.

WIC refers pregnant women enrolled in WIC and parents/guardians of children on WIC who smoke to smoking cessation programs.

EIPP home visitors screen, provide brief interventions, and make referrals with all participants as part of the comprehensive health assessment.

The Alcohol Screening and Assessment in Pregnancy (ASAP2) program screens and refers pregnant women for smoking cessation.

As of July 5, 2004, per the Massachusetts Smoke-Free Workplace Law, all workplaces that have one or more employees must be smoke-free. Designated smoking areas or smoking rooms are not permitted, with limited exceptions. The MDPH has established a 1-800 complaint and information line, fielded 1317 informational calls through April, and investigated 400 complaints. Tobacco Control estimates a 90% compliance with the smoke-free law.

The school nurse intervention program to assist students stop smoking continued.

See also NPM #15.

c. Plan for the Coming Year

This State Performance Measure will be included in our new set of measures.

Tobacco control initiatives for FY06 include "Ready, Set, Quit" initiatives in Worcester and Lawrence. Both of these cities experience high smoking rates among pregnant women and higher smoking prevalence rates among the general public.

In FY06, Tobacco Control plans to initiate a pilot program introducing cessation services at local community/DPH agencies such as WIC or Family Planning. The services would be designed to encourage providers to ask women about their smoking status and provide on-site counseling for those women ready to quit.

FIRSTLink, FOR Families, EIPP, and Perinatal Connections will continue to screen/assess tobacco use and make referrals as needed.

Explore funding opportunities to extend the school nurse intervention program and study, in collaboration with UMass Medical Center.

State Performance Measure 6: *The rate (per 1,000) of chlamydia cases among females aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	12.7	12.7	12.8	14.5	14.5
Annual Indicator	13.4	14.5	17.0	14.9	15.7

Numerator	2760	2973	3488	3065	3224
Denominator	205277	205277	205277	205277	205277
Is the Data Provisional or Final?				Provisional	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data.
Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The 2001 and 2002 denominators are the same as the 2000 denominator, as no 2001 or 2002 population estimates are yet available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) produces the standard population estimates used by the Department of Public Health.
Rates shown may differ from rates previously published or presented in reports from the Division of Sexually Transmitted Diseases, due to differences in the denominators used. Some of the rate change may reflect the adjustment of the denominator based on the Census, and all rates should be considered preliminary until a MISER population estimate has been entered for that year.

Although not the lead agency for the state's STD reduction and treatment efforts, the Bureau supports a number of program efforts to reduce teen risk behaviors that contribute to STDs or assure comprehensive health care, and we work closely with the state STD Program. At the present time, we are projecting rates that will rise only slightly from the estimated FY02 rate and then remain unchanged through 2007. As suggested by the higher than expected apparent rise in the last three years, this may be overly optimistic as any sustained reductions in STDs among teens remain elusive, major disparities continue between white and minority females, and a number of state-funded programs that contribute to the measure are experiencing serious cutbacks.

Notes - 2003

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data.
Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The 2001, 2002, and 2003 denominators are the same as the 2000 denominator, as no additional population estimates are yet available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) produces the standard population estimates used by the Department of Public Health.
Rates shown may differ from rates previously published or presented in reports from the Division of Sexually Transmitted Diseases, due to differences in the denominators used. Some of the rate change may reflect the adjustment of the denominator based on the Census, and all rates should be considered provisional until a MISER or other updated population estimate has been entered for that year.

Although not the lead agency for the state's STD reduction and treatment efforts, the Bureau supports a number of program efforts to reduce teen risk behaviors that contribute to STDs or

assure comprehensive health care, and we work closely with the state STD Program. At the present time, we are projecting rates that will rise only slightly from the estimated FY02 rate and then remain unchanged through 2008. As suggested by the higher than expected apparent rise in the last several years, this may be overly optimistic as any sustained reductions in STDs among teens remain elusive, major disparities continue between white and minority females, and a number of state-funded programs that contribute to the measure are experiencing serious cutbacks.

Notes - 2004

See the Detail Sheet for this measure for definitions of the numerator and denominator and a discussion of the limitations of the data.
Denominators for years through 1999 are from the most recent MISER population estimates; the denominator for 2000 is the Census Count. The resulting denominators and age-specific rates may differ from those previously reported or published elsewhere. The denominators from 2001 forward are the same as the 2000 denominator, as no subsequent population estimates are available from either MISER or MDPH. MISER (the Massachusetts Institute for Social and Economic Research; http://www.umass.edu/miser/) no longer produces the standard population estimates on a regular basis.

Rates shown may differ from rates previously published or presented in reports from the Division of Sexually Transmitted Diseases, due to differences in the denominators used. Some of the rate change may reflect the adjustment of the denominator based on the Census, and all rates should be considered provisional until a MISER or other updated population estimate has been entered for that year.

This measure is being eliminated as part of our 5-year needs assessment and establishment of new State Performance Measures.

a. Last Year's Accomplishments

BFCH staff completed its collaboration with the Division of Medical Assistance's Chlamydia Education Project. The project's goal was to educate MassHealth physicians to increase sexual history taking and Chlamydia screening for adolescent females ages 15-17 who are enrolled in MassHealth. The project was completed with the production of a Chlamydia Toolkit for Clinicians.

Science-based teen pregnancy prevention programs and coalitions implemented 214 on-going primary prevention activities specifically focused on STI prevention.

For female clients aged 15-19, over 35% of SBHC visits to female clients in FY03 involved clinical assessment for STI/STD risk. An STI/STD diagnosis was reported in over 1.4% of visits to female clients; an estimated 8% of SBHC visits to female clients involved medical screening or treatment for chlamydia. [This estimate was based on specific clinician-ordered tests to detect the chlamydia antigen (Procedural CPT codes) and chlamydia-related diagnostic codes. The estimate does not include less specific, ubiquitous urine or blood panels that may or may not have been ordered to detect chlamydia.]

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Screening, diagnosis, treatment and counseling on Chlamydia in statewide family planning clinic system	X			
2. Collaboration between Family Planning and STD program to expand		X		X

coverage for Chlamydia treatment				
3. Screening, treatment and counseling in SBHCs and funded primary care sites	X			
4. ESHS K-12 health education programs are encouraged to include reproductive health			X	
5. Provider training and TA to increase skills in sexual history taking and Chlamydia screening				X
6. MassCARE clinics screen all enrolled women for STDs, including chlamydia, in conjunction with HIV testing	X			
7. Home Visiting programs counsel women and teens on STDs and HIV		X		
8. Teen pregnancy prevention programs provide information on STI prevention and referrals to health services for testing		X		
9.				
10.				

b. Current Activities

Family planning agencies continue collaboration with the CDC Infertility Project (Chlamydia Project) that provides funding for universal Chlamydia screening in specific high-risk communities.

Collaboration continues between the Family Planning program and the Bureau of Communicable Disease Control's STD program to provide additional funding for Chlamydia treatment for Chlamydia Project participants.

Ongoing annual collection of Chlamydia performance measure for family planning clients 15 - 25 years of age.

SBHC clinical training is ongoing through collaboration with the STD/HIV Prevention Training Center. Clinicians receive "Chlamydia Tool Kits" with most recently developed CDC guidelines and protocol recommendations. Prevalence and demographic trends data is discussed at clinical provider meetings.

A new screening Chlamydia urine test was implemented in all SBHC sites in collaboration with the MDPH State Lab Institute. The elimination of a requirement for refrigeration during transport will make the new technology much more accessible to remote SBHCs, removing a major barrier to widespread screening.

FIRSTLink, FOR Families, EIPP programs provide health education and guidance on avoidance of STIs and make referrals to health care and family planning providers.

MassCARE providers provide health information and education about chlamydia and other STIs and refer young women to the appropriate health care providers for treatment.

All Teen Pregnancy Prevention programs are implementing programs that will reduce the incidence of unprotected sex, delay the initiation of sexual intercourse, provide sex education, including information on abstinence and contraception, and increase the use of condoms among youth ages 10-19.

Also see activities in NPM #08.

c. Plan for the Coming Year

This measure (or a close variant of it) will not be included in our State Performance Measures in future years. Therefore, no Plans for the Coming Year are included.

State Performance Measure 8: *The degree to which the State assures nutrition screening and education, with referrals to assessment, counseling and services as indicated, for pregnant women, children and adolescents.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	22.11	28.56	35.9	33.7	41.8
Annual Indicator	22	26	34	34	45
Numerator	22	26	34	34	45
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

This measure is scored from a Checklist which includes five components, each of which is scored on scales that produce a maximum weighted score of 10: 1) assurance that nutrition screening and education, along with referrals to assessment, counseling, and services as needed, are available to all pregnant and post-partum women, infants, children and adolescents (including those with special health care needs) in all MCH-funded direct service programs; 2) assurance that referrals to WIC are made for all eligible clients of all DPH-funded MCH programs; 3) adoption and promotion of comprehensive nutrition screening standards for pregnant and post-partum women, infants, children and adolescents; 4) establishment and use of a Work Group to identify and prioritize nutrition-related health issues and to investigate intervention strategies; and 5) implementation of strategies to address the priority issues identified through the Work Group. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of State Performance Measure 8 (in Part IV, Section D. of our Narrative Application), with the FY02 scoring by component shown.

The measure was thoroughly reviewed and reconstituted during our Needs Assessment process. Previous scores have not been modified. It addresses a large number of systems attributes and relies on data and qualitative assessments from a number of sources and viewpoints. We continue to find no single measure of nutritional status appropriate or available on a population basis, and thus continue to opt for a measure of comprehensive systems development as an intermediate outcome. The effectiveness of the new version of this

measure will continue to be monitored.

Notes - 2003

This measure is scored from a Checklist which includes five components, each of which is scored on scales that produce a maximum weighted score of 10: 1) assurance that nutrition screening and education, along with referrals to assessment, counseling, and services as needed, are available to all pregnant and post-partum women, infants, children and adolescents (including those with special health care needs) in all MCH-funded direct service programs; 2) assurance that referrals to WIC are made for all eligible clients of all DPH-funded MCH programs; 3) adoption and promotion of comprehensive nutrition screening standards for pregnant and post-partum women, infants, children and adolescents; 4) establishment and use of a Work Group to identify and prioritize nutrition-related health issues and to investigate intervention strategies; and 5) implementation of strategies to address the priority issues identified through the Work Group. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of State Performance Measure 8 (in Part IV, Section D. of our Narrative Application), with the FY03 scoring by component shown.

The measure was thoroughly reviewed and reconstituted during our Needs Assessment process. Previous scores have not been modified. It addresses a large number of systems attributes and relies on data and qualitative assessments from a number of sources and viewpoints. We continue to find no single measure of nutritional status appropriate or available on a population basis, and thus continue to opt for a measure of comprehensive systems development as an intermediate outcome. The effectiveness of the new version of this measure will continue to be monitored.

Notes - 2004

This measure is scored from a Checklist which includes five components, each of which is scored on scales that produce a maximum weighted score of 10: 1) assurance that nutrition screening and education, along with referrals to assessment, counseling, and services as needed, are available to all pregnant and post-partum women, infants, children and adolescents (including those with special health care needs) in all MCH-funded direct service programs; 2) assurance that referrals to WIC are made for all eligible clients of all DPH-funded MCH programs; 3) adoption and promotion of comprehensive nutrition screening standards for pregnant and post-partum women, infants, children and adolescents; 4) establishment and use of a Work Group to identify and prioritize nutrition-related health issues and to investigate intervention strategies; and 5) implementation of strategies to address the priority issues identified through the Work Group. See Notes to Form 16 (Detail Sheet) for details on components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of State Performance Measure 8 (in Part IV, Section D. of our Narrative Application), with the FY04 scoring by component shown.

The measure is being retired as part of our 5-year needs assessment process and establishment of new State Performance Measures. A new measure related to promotion of healthy weight is being substituted.

a. Last Year's Accomplishments

The attached checklist to score this measure shows the components, the possible scores for each component, and how the score was calculated.

FOR Families home visitors assessed nutrition status and food security and made referrals. WIC provided on-site nutritional counseling to homeless families.

40% of EIPP participants in FY04 reported inadequate food or clothing. Of the 314 EIPP participants who received comprehensive health assessment, 68% were found to have a low or moderate level of strength in maternal/infant nutrition. 43 EIPP participants were referred to WIC, 36 to a local food bank and 36 to Food Stamps. An additional 139 were supported in their current WIC services.

CPCP and WIC program staff coordinated an intensive update and review for all CPCP and WIC program contracts. Agencies reviewed and revised their local program coordination agreements for comprehensive, unduplicated and timely services for combined primary care and WIC and revised mutual agreements for high-risk protocols, referral and tracking procedures that ensure timely entry into primary care services and the WIC program, and coordination for other high-risk referrals.

The Nutrition and Physical Activity Unit (NPAU) collaborated with:
- MA Action for Healthy Kids team on the development of the "Massachusetts A La Carte Food and Beverage Standards to Promote a Healthier School Environment."
- Tufts University to conduct a statewide inventory of physical activity opportunities across the state to create a searchable database for consumers about resources in their areas.
- Children's Hospital in Boston to produce a manuscript on the findings of the Ambulatory Management of Childhood Overweight survey results.
- Partnership for Healthy Weight's Screening Diagnosis and Treatment Task Force on the Resource Guide for Pediatric Overweight Treatment in MA, a need in the physician survey.

Facilitated 5 A Day regional coalitions in the west and southeast. Information on potential members for Boston, metro west and central were collected

Held meetings with MA Health representatives to identify reimbursement practices for nutrition counseling by registered dietitians. Recommended that MA Health meet with Primary care unit staff to learn practices in community health centers.

Results from the statewide Ambulatory Management of Childhood Overweight Survey by the Partnership for Healthy Weight Screening Diagnosis and Treatment Task Force were presented to several groups including the MCAAP Obesity subcommittee and the MCH workgroup of Mass Health, which includes MCO providers who provide insurance coverage to high-risk, low income populations.

In FY03, 6% of SBHC visits by the MCH population involved screening/assessment for at least 1 nutrition-related indicator.

Of the Essential School Health Services school districts, 40.8% held nutrition support groups in FY04 and over 53,766 students were screened for BMIs; 15.6% in the sample had a BMI > 95th percentile. All were increases from FY03.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All WIC participants receive nutritional assessments, counseling and referrals as needed	X	X		
2. Guidelines and standards for all BFCH direct service programs include nutrition screening, education and referral				X

3. Combined meetings and ongoing training of WIC and MCH primary care nutritionists				X
4. Multidisciplinary outpatient evaluation and treatment for children with growth delays are provided to promote proper health, development, and nutrition	X	X		
5. SBHCs have guidelines for nutrition screening, and guidelines are being developed for inclusion in other RFR contract conditions for services to women, children and adolescents				X
6. Internal DPH working group established to develop a strategic plan for systematic collection of objective weights and heights (and BMI) in school age children				X
7. The ESHS programs are beginning to do BMIs with a focus on grades 1, 4, 7, and 10 and are working to improve the nutritional environment in schools	X	X		X
8. Continue to implement the MA Partnership for Healthy Weight network to reduce overweight, obesity and weight-associated disease (initial focus on youth), through State Action Plan, environmental supports, evidence-based strategies, and surveillance				X
9. Home visiting programs assess nutritional status of pregnant women and their families and provide education, resources, and referrals		X		
10.				

b. Current Activities

WIC participants receive nutrition assessment/counseling/education at certification, and a minimum of 1 follow-up education visit. High-risk clients receive monthly follow-up. Nutrition education is provided individually and in interactive group sessions.

Coordinate the Nutrition Workgroup Meeting and 3 ongoing task forces for effective, comprehensive, culturally-appropriate nutrition services and educational materials.

WIC is implementing a 3-year USDA Special Projects Grant, "Touching Hearts and Minds: Using Emotion-Based Messages to Promote Healthy Behaviors."

Staff at six local WIC programs are piloting an emotion-based nutrition education and counseling strategy to test 30 different nutrition education materials/messages with mothers of children birth to 3.

Engage in efforts to improve collaboration and promote unduplicated, comprehensive nutrition services between the WIC program, Early Intervention, Growth & Development, Primary Care and Head Start nutrition services.

ESHS programs continue to meet screening and referral and systems/policy standards. School nurses receive BMI training and execute nutrition/physical activity programs. SBHC training includes BMI monitoring & healthy weight promotion and participation in the School Health Index assessment for an ecologic approach to the problem of obesity prevention. MA DOE and the Coordinated School Health program are developing a model nutrition policy. These and other school-related initiatives are in the Massachusetts Overweight Prevention and Control Initiative state plan.

Established a website to improve public access to information on current nutrition, physical activity and weight management programs.

Collaborated with the Partnership for Healthy Weight's Screening Diagnosis and Treatment

Task Force to disseminate 5000 copies of the Pediatric Guide with an evaluation tool included. The guide is posted on the MCAAP NPAU and MA Health Promotion Clearinghouse web sites.

Facilitates meetings with western regional and statewide 5 A Day coalition focused on sharing resources and promising practices.

Conducted qualitative formative research on the efficacy of the 5-2-1 (eat 5 servings of fruits and vegetables a day; limit screen time to no more than 2 hours a day; get at least 1 hour of physical activity a day) health promotion message with middle school aged children and their parents.

Family Planning program standards include nutrition screening/referral and providing information on folic acid. Compliance with standards was assessed at all vendor site visits and TA provided as needed. Particular attention is paid to nutritional issues such as calcium intake and weight monitoring.

FIRSTLink and EIPP screen for nutritional needs & food security, including infant feeding issues. They provide education and referrals to food resources including WIC, food stamps, and pantries. F0R Families assesses and refers homeless families. WIC provides on-site enrollment and counseling to homeless families.

c. Plan for the Coming Year

A related measure will be included as a new State Performance Measure for future years.

The NPAU (MOPCI program) will continue to support statewide efforts of the Partnership for Healthy Weight to implement the statewide plan to reduce overweight and obesity through its participation in the Executive Committee.

Healthy Choices regional coordinators will be trained on use of the Massachusetts A La Carte Food & Beverage Standards to Promote a Healthier School Environment" to help facilitate change and improve ala carte/competitive foods in the Healthy Choices schools.

The NPAU will facilitate the development of a searchable web site to allow consumers and providers access to information on physical activity opportunities across the state.

A six month evaluation of the Resource Guide for Pediatric Overweight Treatment in MA will be conducted. The results will be shared with health care provider groups and will inform plans for updates and further dissemination.

The NPAU in collaboration with its 5 A Day partners will research promising practices and evidence based practice related to fruit and vegetable consumption; expand regional and statewide membership of coalitions; evaluate the impact and use of available education materials; and continue to disseminate 5 A Day materials through the MA Health Promotion Clearinghouse. The NPAU will explore opportunities for integration of 5 A Day into regional and statewide coalitions and groups working on improving health of population. A yearly educational event will be coordinated during National 5 A Day Month.

The NPAU will continue working with interested partners to develop a plan of action for increasing reimbursement for nutrition services. Potential partners that will be approached include the Mass League of Community Health Centers and the Massachusetts Dietetic Association.

The NPAU will use the formative research on the 5-2-1 message to develop a communications campaign to educate middle school aged children and their parents on various strategies to

reduce their risk of overweight and obesity.

FOR Families, FIRSTLink, EI Partnerships and Perinatal Connections will continue to assess the nutritional needs of families and provide counseling, resources and referrals as needed.

State Performance Measure 10: *The degree to which the state has developed and implemented comprehensive education, screening and referral protocols for violence against women and children (on scale from 0 to 16).*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	3	7	1	6	10
Annual Indicator	3	4	2	8	10
Numerator	3	4	2	8	10
Denominator	1	1	1	1	1
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

This measure was new with our FY01 Application and was developed in conjunction with a new priority area (violence against women and children) identified through our Needs Assessment. Based on experience in the first two years of use, this measure has been modified for FY02 and future years and. It has four components, each with a maximum score of 4, for a maximum total score of 16: 1) development of comprehensive protocols (core and setting-specific) related to violence against women and children (for patient education, screening, care and referral) for all MCH-related program types; 2) percentage of MCH-related programs with developed and approved protocols; 3) degree to which comprehensive education and training curriculum is developed and delivered prior to implementation of screening, care and referral protocols; and 4) percentage of MCH-related programs with protocols that have implemented provider training with developed curriculum.
See Notes to Form 16 (Detail Sheet) for details on the revised components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of State Performance Measure 8 (in Part IV, Section D. of our Narrative Application), with the FY02 scoring by component shown.

Notes - 2003

This measure was new with our FY01 Application and was developed in conjunction with a new priority area (violence against women and children) identified through our Needs Assessment. Based on experience in the first two years of use, this measure was modified for FY02 and

future years. It has four components, each with a maximum score of 4, for a maximum total score of 16: 1) development of comprehensive protocols (core and setting-specific) related to violence against women and children (for patient education, screening, care and referral) for all MCH-related program types; 2) percentage of MCH-related programs with developed and approved protocols; 3) degree to which comprehensive education and training curriculum is developed and delivered prior to implementation of screening, care and referral protocols; and 4) percentage of MCH-related programs with protocols that have implemented provider training with developed curriculum.
See Notes to Form 16 (Detail Sheet) for details on the revised components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of State Performance Measure 8 (in Part IV, Section D. of our Narrative Application), with the FY03 scoring by component shown.

Notes - 2004

This measure was new with our FY01 Application and was developed in conjunction with a new priority area (violence against women and children) identified through our Needs Assessment. Based on experience in the first two years of use, this measure was modified for FY02 and future years. It has four components, each with a maximum score of 4, for a maximum total score of 16: 1) development of comprehensive protocols (core and setting-specific) related to violence against women and children (for patient education, screening, care and referral) for all MCH-related program types; 2) percentage of MCH-related programs with developed and approved protocols; 3) degree to which comprehensive education and training curriculum is developed and delivered prior to implementation of screening, care and referral protocols; and 4) percentage of MCH-related programs with protocols that have implemented provider training with developed curriculum.

See Notes to Form 16 (Detail Sheet) for details on the revised components and scoring. See the Detail Sheet (in Form 16) for this measure for definitions and discussions of its significance and development. The Checklist itself is provided as an Attachment to the “Last Year’s Accomplishments” sub-section of State Performance Measure 8 (in Part IV, Section D. of our Narrative Application), with the FY04 scoring by component shown.

The measure is being retired as part of our 5-year needs assessment process and establishment of new State Performance Measures.

a. Last Year's Accomplishments

The attached Checklist displays the components of the measure, the possible scores for each component, and how the FY04 score was calculated. Details discussed below.

The Domestic Violence Screening, Referral and Information Program (DV SCRIP) was formed in FY02 to improve the quality of care provided to women and children served by MDPH funded programs. In FY04 the final draft of a comprehensive domestic violence program guide was completed specifically for use with MCH providers to provide education and training regarding screening, care, and referral for violence against women and children. With the program guide complete, and building on the work done in previous years with the Early Intervention Prevention Partnership, DV SCRIP began to work collaboratively with additional MCH programs on implementation.

Collaborate with WIC on how to train WIC providers on issues of domestic violence. Informational meetings were scheduled with each main WIC program in FY05. An assessment tool was developed to assess each program's current level of awareness, policies and protocols regarding domestic violence.

Provided leadership of the BFCH Advisory Group on domestic violence protocols. This Advisory Group will continue to play a key role in the development of the Department's

comprehensive protocol and its implementation.

Two abstracts were accepted for presentation at the Family Violence Prevention Fund's National Conference on Healthcare and Domestic violence held in October 2004.

All EIPP Home Visitors participated in the DV SCRIP Training. Sixteen percent (16%) of EIPP participants served in FY04 reported experiencing violence in the home at the time of intake. Of the 314 EIPP Participants who received an initial comprehensive health assessment, 52% were found to have either a low or moderate level of strength in the area of interpersonal violence indicating a risk that prompted further examination and the provision of health education. Eleven EIPP participants were referred to family/interpersonal violence prevention services and an additional 10 were supported in maintaining their violence prevention services.

Rape Crisis center staff met with family planning staff to improve linkages and referrals, to educate them on emergency contraception and provided training of family planning providers.

In FY03, approximately 8% of SBHC visits to the MCH population involved surveillance for at least one aspect of violence or abuse. The violence assessment included screening for violent behavior or the witnessing thereof, and the possession of weapons. The abuse assessment included screening for sexual, physical, and/or emotional abuse.

The Winter 2004 edition of "Updates in School Health" (circulation of 3,800 and on the web) had a focus on preventing intentional injuries and included articles on teen dating violence, responding to perpetrators of teen dating and domestic violence, the SANE program, and updates on the Massachusetts Rape Crisis Centers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. All BFCH programs providing services to women/children are expected to screen and refer for violence		X		
2. Violence screening, education, and referral protocols are being included in BFCH RFR/contract conditions				X
3. Comprehensive curriculum for use by MCH providers regarding violence against women and children				X
4. Training using the comprehensive curriculum is provided to MCH providers				X
5. Comprehensive screening protocols have been developed for MCH providers, including materials for preparing the program, assuring staff safety, and appropriate screening tools				X
6. Information on violence prevention is regularly shared with school nurses; reporting of 51As is tracked through the ESHS reports.				X
7.				
8.				
9.				
10.				

b. Current Activities

Throughout this year, DV SCRIP has continued working with WIC Providers and is starting

work with the Family Planning programs. DV SCRIP assesses programs training needs, and offers training and technical assistance regarding domestic violence, safety issues, and best practice screening and protocols.

Prior to conducting trainings with WIC staff, DV SCRIP held informational meetings at all 36 main WIC sites. The meetings were to assess each program's current level of awareness, policies and protocols regarding domestic violence. Also, the meetings served as a way to get input from staff on their specific training needs.

DV SCRIP has conducted 19 domestic violence trainings for the WIC Programs. Over 450 staff have been trained this year. This training provides participants with information regarding the dynamics of domestic violence, with specific attention to concerns that may arise for particular MCH subpopulations (pregnant women, adolescents, children who witness violence), and then provides information regarding intervention and referral. The training includes important information regarding preparing the program environment for addressing domestic violence as well as safety issues for clients and provider staff. Four local WIC programs have volunteered to pilot domestic violence screening at their sites.

DV SCRIP presented on the Maternal and Child Health Curriculum at the Family Violence Prevention Fund's National Conference on Health Care and Domestic Violence in October 2004.

Ongoing collaboration between the Family Planning and the SANE Programs includes participation on the SANE Board and recruitment of family planning clinicians to be preceptors for SANE nurses.

Family Planning programs are expected to screen and refer for actual or potential violence. Provider training needs are assessed, and training and technical assistance regarding domestic violence, safety issues, and best practice screening and protocols are provided. Ongoing program monitoring assesses compliance with program standards, including specific protocols and standards on violence screening and prevention. Program standards have been revised and updated to strengthen the requirements regarding staff training, assessment and referrals for intimate partner violence, to increase capacity of the family planning staff to handle these issues.

FIRSTLink, EIPP, and FOR Families home visitors and telephone responders screen for violence against women and children (including the homeless) and make appropriate referrals as necessary.

The Violence Prevention Programs is providing training to School-Based Health Center clinicians on screening and referrals/resources for relationship violence and sexual abuse.

Continuation of School Health Institute programs on violence prevention and completion of chapters for the revised school health manual on violence prevention and reproductive health.

c. Plan for the Coming Year

A similar measure will be included as a State Performance Measure for the future.

New procurement and contractual language and guidelines will be drafted that require violence against women and children issues to be addressed in all future RFRs and resulting new contracts with MCH providers. This work will build on the experience and model of the development of the EI Partnership procurement in FY03, in which domestic violence criteria were included and well defined in the RFR specifications, and on the best practice protocol recommendations being developed by the DV SCRIP project advisory group.

Over the next year, work will continue with the WIC programs to implement new requirements regarding domestic violence and programs will develop and implement DV policies and protocols.

Over the next year, the Family Planning program will implement new requirements regarding domestic violence; programs will develop and implement DV policies and protocols, providers will receive training on the DV SCRIP curriculum, address domestic violence issues and make appropriate referrals.

In conjunction with the Boston Public Health Commission, a brief screening tool that addresses domestic violence, substance abuse and mental health issues will be replicated in pilot community health centers statewide. During FY06, the goal is to implement the screening tool at 3 sites. Providers will be trained on the use of the tool and provided information on appropriate community resources for referrals.

E. OTHER PROGRAM ACTIVITIES

In addition to activities contributing to performance measures, a majority of Bureau programs conduct one-time and/or on-going activities directly focused on meeting one or more of the State's currently defined Priority Needs. A description of these activities is attached to this section of the application. Plans for FY06 are included for Priority Needs that will continue as a result of our Five-year Needs Assessment. Also in the attachment is a comprehensive list of MCH-related programs and service numbers for FY04, by MCH population categories.

F. TECHNICAL ASSISTANCE

Massachusetts is again making a specific request for Technical Assistance to assist in undertaking a CAST 5 Assessment. After significant changes in state resources and restructuring of the Department into larger Centers, CAST 5 would provide a better understanding of current resources and needed rebuilding or enhancements to assure strong MCH/CSHCN services. Although this was our original planned request for FY05, it was deferred as we joined the other Region I states in obtaining Technical Assistance support for a regional poison control symposium and meeting.

V. BUDGET NARRATIVE

A. EXPENDITURES

Expenditures Narrative

See the FY04 Expended columns in Form 3 (State MCH Funding Profile), Form 4 (Budget Details by Types of Individuals Served), and Form 5 (State Title V Programs Budget and Expenditures by Types of Services). The Form and Field Notes for the Forms provide extensive additional details and explanations about the amounts shown, including differences between budgeted and expended amounts, changes in the levels of funding categories across years, and the sources of state Partnership funds and other Federal funds.
It is important to note that throughout these changes and variations from original budgets, the distribution of expenditures from the federal portion of the Title V Partnership remained much more stable. Due to the increasingly categorical nature of much of our state funding, we are not always able to shift it to moderate secular changes in funding levels or to target our highest MCH priorities. Because the ratio of total state funding was so much higher than our federal allocation (over 5 to 1), patterns in state funding drive the patterns seen in the total Partnership budget and expenditures.

Three aspects of the Expenditures warrant narrative discussion:
1. The difference between the FY04 Unobligated Balance originally budgeted and the amount expended.
2. The difference between the total Partnership funding budgeted for FY04 and final expenditures (Form 3) and between FY04 and the previous year.
3. Several substantial differences between the amounts budgeted for FY04 and final expenditures by MCH Population Group (Form 4) and by Level of the Pyramid (Form 5).

1. The FY04 Unobligated Balance expended is substantially higher than the amount originally budgeted. We generally do not fully budget the sum of the new allocations and the carryover from the previous year; therefore the sum of lines 1 and 2 in any Budgeted Column is not the same as "Total Funds Available." The precise amount of carryover cannot be calculated at the time the new budget is prepared, as accounts payable extends for approximately 3 months after the close of the state fiscal year.
The other systematic difference between the Federal Budgeted and Expended Columns is that when showing the budget, the new federal award is shown in full (per instructions) and only the amount of unobligated carry-forward funds necessary to meet our program needs is budgeted. However, expenditures are always paid first with the "oldest" federal funds, not the new award. Therefore for expenditures, only the amount of the new grant needed to make all budgeted payments is actually expended. The final federal balance forward for FY04 was $2,119,713, whereas only $1,804,957 had been budgeted originally.
Some other differences between Form 3 for FY04 and the previous year are highlighted below.
The amount of State Funds expended in FY04 ($69,129,506) was slightly higher than the amount originally budgeted ($69,075,127), due to a late state supplemental budget with increased funds for family Planning and Rape Crisis Centers that passed after our final revisions were submitted. Overall the FY04 state funding was less than in FY03. This was due in part to reductions in Healthy Start and CMSP state funds. [These accounts were transferred out of the Department of Public Health at the end of FY04 and staff support ended early in FY04.] In addition, state funding remained reduced for a number of Partnership accounts. There were no mid-year reductions during FY04.

2. Form 4 (Budget by MCH Population Groups). Final FY04 Expended totals are significantly different from FY04 Budgeted totals for Infants, Others, and Administration. The lower Infant expenditure is principally due to the reduction in total "shared" expenditures by about $1.2M from their initial budgeted level, due to staff vacancies and some cost shifting to non-Partnership accounts. These Shared costs (either budgeted or expended) are allocated across the MCH population categories in proportion to each category's share of direct costs. Thus the savings in Shared costs helps account for the lower expenditures in all categories, but because of the relatively small total for Infants, the effect is magnified enough to trigger the TVIS filter of a 10% difference. Adding to this impact,

expenditures for the start-up year of the Early Intervention Partnership program ran almost $300,000 less than initially budgeted.
The apparently higher expenditures for Others are in part an artifact of correcting an error in the allocation of Family Planning state dollars in the FY04 budget document. They were mistakenly largely assigned to Category D (children with special health needs) rather than to Category E (Others) and to Category C (Children ages 1 -- 22). This error has been corrected in the final Expended calculations. In addition, state funding for Rape Crisis Centers and Family Planning was increased after the final revision to our FY04 application through a state supplemental budget, further raising the FY04 expenditure level. Because all of the funds involved in these changes were state, none of the federal required percentages for either children and adolescents or for children with special needs were affected. The overall decrease in administrative expenditures reflects two different situations in FY04. First, with some changes in how state personnel costs are charged, a number of non-MCH-related state administrative expenses were removed entirely from the Partnership budget calculations -- for clarity and consistency. [They are no longer a portion of the accounts that we consider part of the partnership and can more easily be separated.] In addition, the Bureau continued to be successful in both reducing overall administration costs and in shifting a number of them to other state and federal accounts that are not part of the Partnership budget. This trend in lower administration costs within the Partnership budget can also be seen in the proposed FY06 budget -- which remains at its lower FY05 level.

3. Form 5 (Budgets by Level of the Pyramid). Final FY04 Expended totals are significantly different from FY04 Budgeted totals for Direct Services. The Expended totals are significantly higher than Budgeted totals for Direct Services for two reasons. First, there was an error in the allocation of the bulk of Family Planning state dollars in the FY04 budget document to Enabling Services rather than to Direct Services. This error has been corrected in the final Expended calculations and accounts for about $1M of the difference. In addition, state funding for Family Planning was increased after the final revision to our FY04 application through a state supplemental budget, further raising the FY04 expenditure level.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and service types in a variable manner from year to year. This picture is misleading, however, because these Forms present the entire MCH Federal-State Partnership budget, which in our case is approximately 80% state funds (compared with 83% in FY04 and 87% in FY03). We have flexibility in allocating federal Block Grant funds, while the populations to be served by state appropriations are usually closely controlled by the more categorical or earmarked nature of state budget language. A more accurate picture of our commitment to the MCH Populations and Types of Services may be seen in the tables attached to Part V, Section B, which presents data with federal funds and state funds separately over several years. These tables illustrate that virtually all of the year to year variation in the relative distribution of funds across population groups is due to variations in state funding.

B. BUDGET

The budget proposed for FY06 in Forms 2, 3, 4, and 5 contains some significant differences with those of previous years. Overall, state funding has dropped over the last several years, but now appears to stabilizing again, although at levels below historic bases. The drop since FY04 has to do primarily with the transfer of two major and long-standing state health insurance programs for pregnant women and children -- Healthy Start and Children's Medical Security Program -- out of the Department of Public Health and the state Title V agency to the state Medicaid and SCHIP programs.

The total Partnership budget of $69,562,467 is made up of $13,283,939 of MCH Block Grant funds (including carry-forward funds) and $56,278,528 in state funds. Massachusetts continues to commit funds above our statutory maintenance of effort level from FY1989 of $23.5M and the state funding represents a FY06 State Match ($3 state for every $4 federal) of $9,962,954 and State Over Match of $46,315,574. The total state funds represent all or portions of 9 state accounts (Family Health Services, Early Intervention (2 accounts), Teen Pregnancy Prevention, Universal Newborn Hearing,

Dental Health, School Health (including School-Based Health Centers), one Interagency account with Medicaid, and state administration). Details on the budgeted amount from each account are given in the Notes to Form 3.

Massachusetts continues to budget at least 30% of our federal MCH funds for Preventive and Primary Care for Children (30.23% in FY06) and for Children with Special Health Care Needs (30.79% in FY06). The proportion of federal funds used for Title V Administrative Costs continues to be well below the allowable 10% (7.4% in FY06), as we have been more successful in sharing those costs with other state and federal sources in an equitable manner.

The state revenue picture continues to fluctuate. While the budget improved in FY06, continuing the restoration of several MCH-related accounts that occurred in FY05, it continues to be below FY03 or earlier levels for most accounts. The total state funding is down from $90,889,935 in FY03. After adjusting for the transfer of Healthy Start and CMSP (which both are funded at MassHealth at levels above FY04), the FY06 state MCH Partnership funding represents a reduction of almost $12M. These reductions and changes have not been uniform and certain types of services and population groups served have been affected more than others. Our oldest and core MCH state account, Family Health Services, the one that most closely resembled the federal block grant and was created originally as the state match, has been reduced over 70% since 1999. This account had contained the only state funding for family planning services, rape crisis centers, the poison control center, MCH primary care wrap-around services, and prenatal/infancy home visiting. After FY04 reductions and modified budget language, it now only funds family planning services, rape crisis centers, and a small amount of MCH primary care wrap-around services. During FY04, $2M was restored (for family planning and rape crisis centers) through a supplemental budget and in FY05 these programs have regained approximately 95% of their FY03 base funding. The final state budget includes some modest additional funding. However, the account remains a narrower and essentially categorical one, rather than the broad-based one its name might suggest.
Details on the budgeted amount from each account, and the amount that it has changed (if relevant) are given in the Notes to Form 3.

The $121,380,751 of other Federal funds shown on Form 3 comes from over 25 different grants, which cover all of the categories on Form 2 except federal Healthy Start. It is important to note that we include all of our WIC funds, state and federal, as they are budgeted in a seamless manner at the state level. Massachusetts funds WIC (both directly and with an infant formula retained revenue account) at almost $37M, which is included in the $121.4M. The Bureau continues to have good success in obtaining a wide range of federal categorical grants. These grants are of great importance in maintaining the breadth of the Bureau's MCH efforts and in continuing our history of innovation and integrated service delivery model development.

Not included in the budget forms is a substantial amount of state funding administered by the Bureau for MCH programs, but which cannot be listed as match by us because the funds are used for match for other federal programs (e.g. TANF or Abstinence Education) or which originate in other state agencies that wish to maintain their options to use the funds for match. As we have a substantial amount of over-match, this is not a budget issue for the Bureau, but it does undercount the level of state support for key MCH services. The programmatic efforts supported by the funds continue to be fully described in our annual reports and plans. Some of the accounts involved are fully MCH-related; the largest of these have been the bulk of the Teen Pregnancy Prevention Challenge Fund ($2,978,786 in FY03, but only $740,000 in FY06) and FOR Families ($1.49M; reduced from $2.2M in FY03); both of these accounts are funded with state TANF funds. Other accounts include both MCH-related and other activities that are difficult to identify precisely or that are needed for potential match for other purposes. These include several state-funded accounts that address sexual assault, batterer intervention, violence and two that support community health center operations and initiatives.

It may appear from Forms 4 and 5 that Massachusetts distributes our funding among MCH Population groups and across types of services in a variable manner from year to year and that certain groups differ significantly in FY05 from their FY04 or earlier shares. This picture is misleading, however,

because Forms 4 and 5 present the entire MCH Federal-State Partnership budget, which in our case is still approximately 80% state funds (down from 87% in FY03). While we have flexibility in allocating federal Block Grant funds, the proportion of the total State Partnership budget that comes from "categorical" state accounts continues to increase and the total, as noted above, can fluctuate significantly from year to year. A more accurate picture of our commitment to the MCH Populations may be seen in the tables in the Excel file that is the attachment to this Part 5, Section B (Budget). These tables present budget data for the federal and state portions of the Partnership budget separately over several years. A comparison of Forms 4 and 5 with these tables illustrates that virtually all of the year-to-year variation in the total and relative distribution of funds across population groups is due to changes (up and down) in state funding. Based on the categorical nature of our state funding stream (and the disproportion cuts in some accounts), the impact of the state funding cuts is not felt equally across all of MCH population groups. These trends continue to place greater strain on the MCH Federal funds (which have not kept up with inflation over the same period) as the only source of flexible funding for many key MCH activities. This strain has previously been felt primarily in the area of Infrastructure Building, as state accounts rarely include funds for systems development, data management, or evaluation. The FY06 budget, although better than FY04, continues to strain our ability to assure core direct, enabling, and population-based services and is altering the shape of many of our programs. These potential changes are discussed throughout our Narrative in the "Current Activities" and "Plans for the Coming Year" segments.

VI. Reporting Forms-General Information

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note

Please refer to Section IX of the Guidance.

X. Appendices and State Supporting Documents

A. Needs Assessment

Please refer to Section II attachments, if provided.

B. All Reporting Forms

Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents

Please refer to Section III, C "Organizational Structure".

D. Annual Report Data

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.